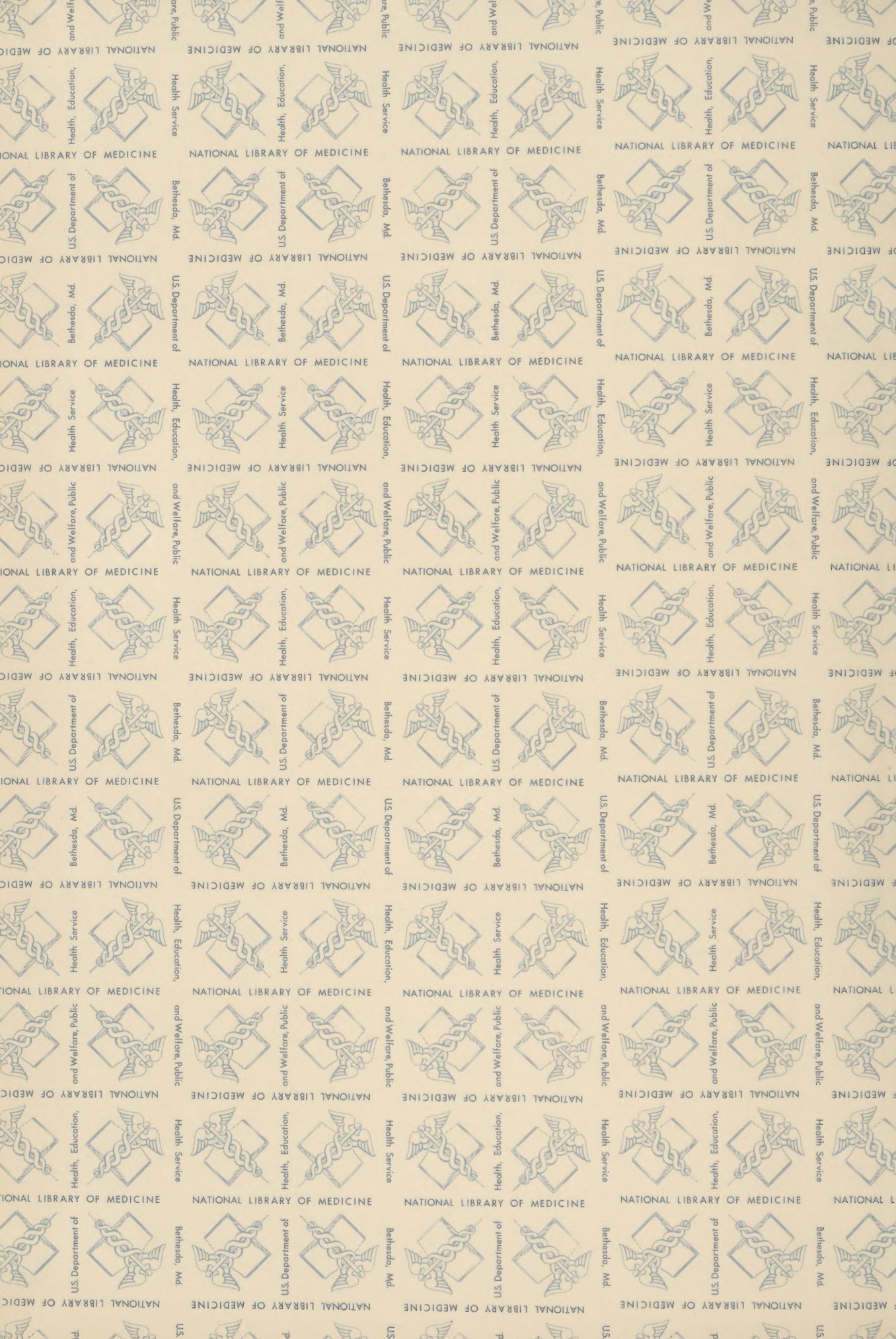

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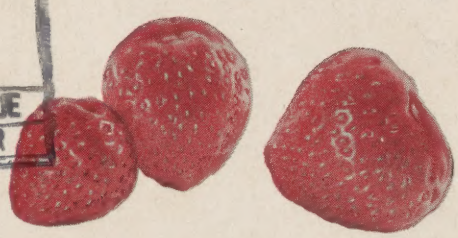
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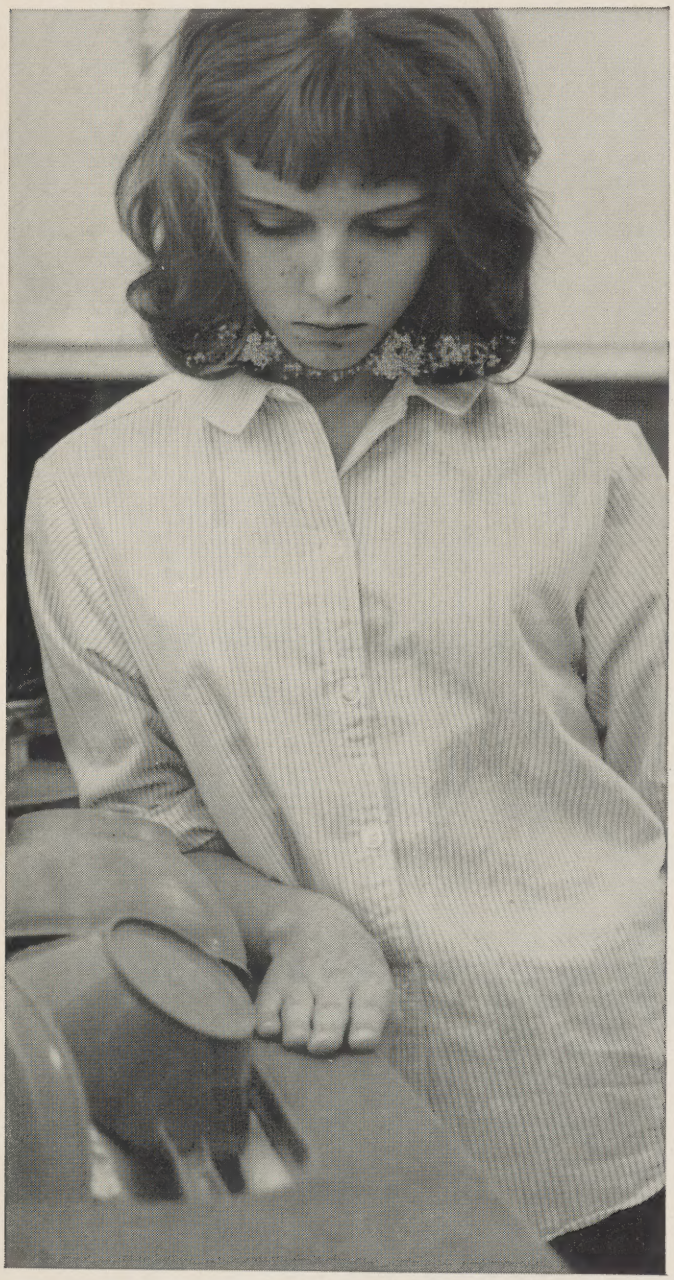
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References: 1. Szymanski, F. J.: *Indust. Med.* 30:498, Nov., 1961. **2.** Wexler, Louis: *Clin. Med.* 70:404, Feb., 1963. **3.** Hodges, F. T.: *GP* 14:86, Nov., 1956. **4.** McLean, I. E. D.; Graham, K. T., and East, M. O.: *Practitioner* 189:82, July, 1962.

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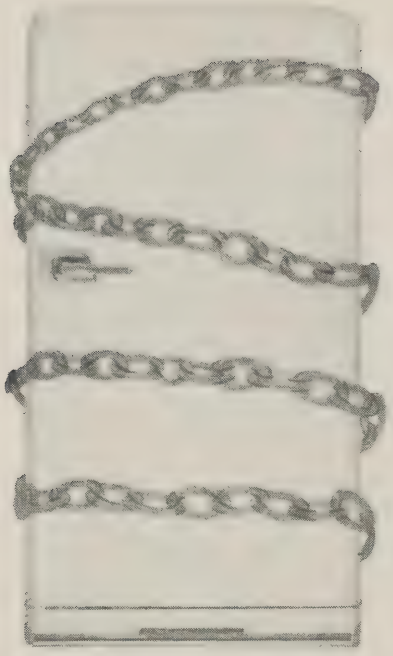
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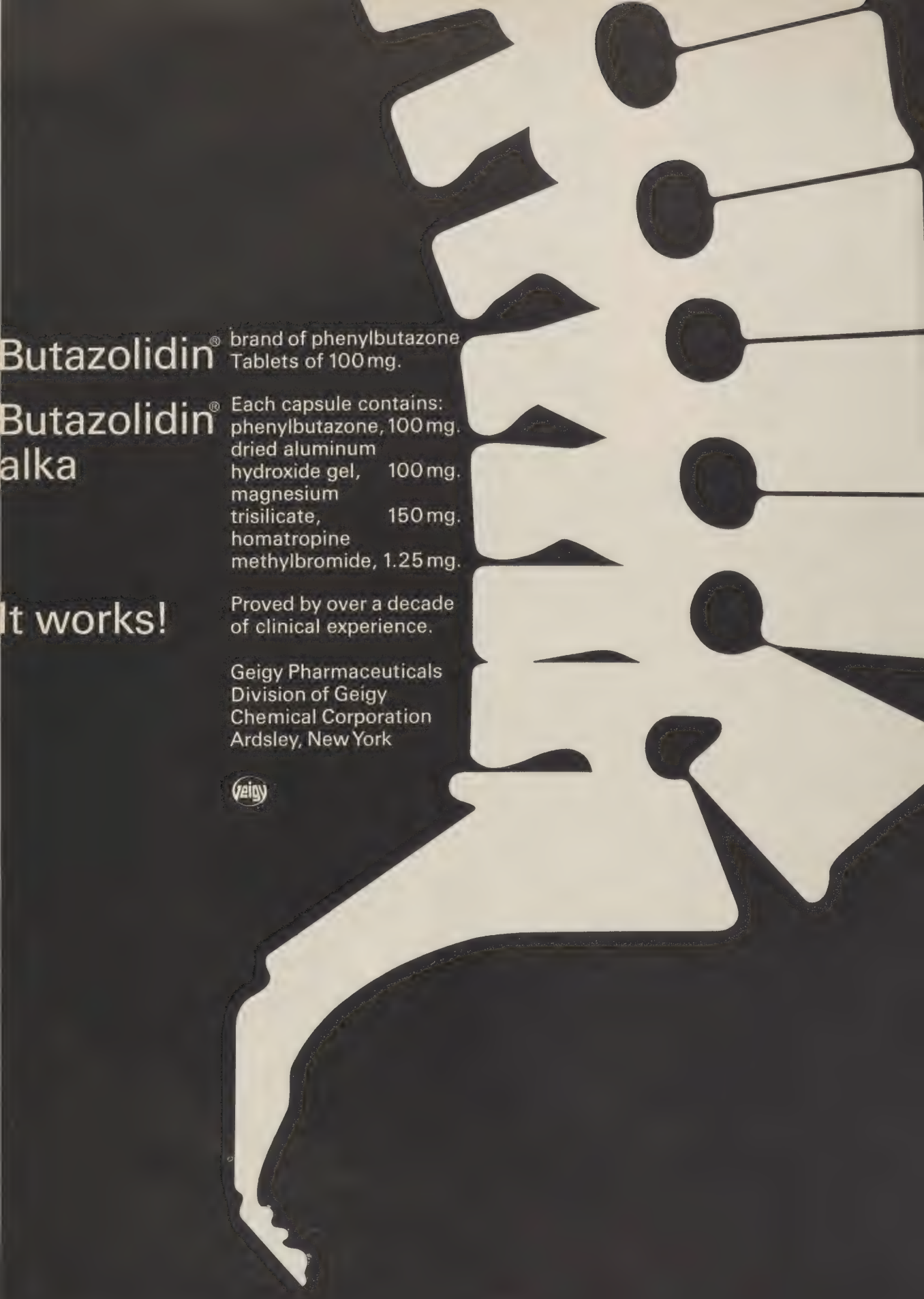
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1. Viglione, J.P.: Clin. Med. *69*:1157 (May) 1962.

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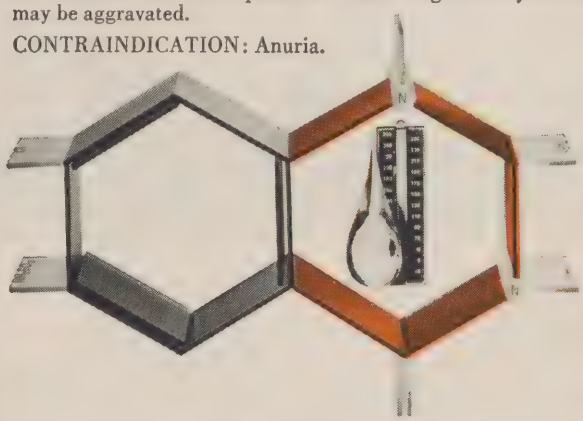
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1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.
2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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VOLUME 60 July, 1964 NUMBER 7

EXFOLIATIVE CYTOLOGICAL STUDIES OF THE CERVIX UTERI:

A Local Survey of 22,773 Cases

WILLIAM PAUL BENNETT, M. D.
Columbia, S. C.

Encouraging evidence continues to accumulate with regard to the efficacy of exfoliative cytology to detect preclinical carcinoma of the cervix. The purpose of this study is to compare the results of a local survey of exfoliative cytologic studies with those of other areas. This will reemphasize the fact that the cytological smear is a useful adjunct to the routine gynecologic examination.

Classification:

For purposes of clarification the following information is given as a classification currently used by the local pathologists and cytotechnologists in this survey:

Class I—Normal appearing cells.

Class II—Atypical cells present, but judged to be benign.

Class III—Atypical cells present, suspicious of malignancy.

Class IV—Atypical cells, probably malignant.

Class V—Atypical cells, almost conclusive of malignancy.

Survey Made During Residency in Obstetrics and Gynecology at Columbia Hospital of Richland County.

Presented at a Meeting of the Columbia Medical Society October 14, 1963.

Classes I and II are accepted as negative in our laboratories. A second smear, however, is suggested on many Class II smears three months following treatment of infection if present.

Classes III, IV and V are regarded as being positive and require histologic investigation.

Results of Survey:

In this study there was a total of 22,773 cervical cytologic examinations made in the laboratories of the Columbia Hospital of Richland County, the South Carolina Baptist Hospital, and the Providence Hospital during the calendar years 1960, 1961, and 1962. Included in this study are private and clinic patients of physicians of both general and specialty practices.

Of the 22,773 cases examined, 240 proved to be positive. Of these 240 patients, 197 had additional diagnostic studies done ranging from punch biopsy of the cervix to total hysterectomy. For various reasons there were no additional diagnostic studies done on the remaining 43 patients.

The following tables give a synopsis of the findings in this survey.

TABLE I
HISTOLOGIC DIAGNOSIS OF PATIENTS WITH CLASS III SMEARS

Diagnostic Method	Cervicitis, Chronic	Atypical Hyperplasia	Carcinoma In Situ	Invasive Carcinoma	Total
Punch Biopsy	31	2	1	18	52
Cone Biopsy	17	26	41	1	85
Punch Biopsy and Hysterectomy	2	1	2	1	6
Hysterectomy Only	0	0	2	0	2
Total	50	29	46	20	145

As shown in Table I, 46 (31.7%) of the 145 patients with Class III smears had carcinoma in situ of the cervix; 20 (13.8%) had either invasive carcinoma of the cervix, vagina or body of the uterus involving the cervix; and 20 (20%) had atypical hyperplasia of the cervical epithelium. Thus, 95 (65.5%) of these patients had atypical changes warranting either definitive treatment or further closely supervised care.

TABLE II
HISTOLOGIC DIAGNOSIS OF PATIENTS WITH CLASS IV SMEARS

Diagnostic Method	Cervicitis, Chronic	Atypical Hyperplasia	Carcinoma In Situ	Invasive Carcinoma	Total
Punch Biopsy	2	0	2	17	21
Cone Biopsy	5	3	18	3	29
Punch Biopsy and Hysterectomy	0	0	0	0	0
Hysterectomy Only	1	0	1	0	2
Total	8	3	21	20	52

Of the 52 patients shown in Table II with Class IV smears, 21 (40.4%) had carcinoma in situ of the cervix; 20 (38.5%) had either invasive carcinoma of the cervix, of the uterus involving the cervix or of the ovary metastatic to cervix; and 3 (5.8%) had atypical hyperplasia of the cervical epithelium. Thus, 44 (84.6%) had important histologic abnormalities.

A summary (Table III) shows that of the 197 patients having positive smears investigated with at least a cervical biopsy, 67 (34%) had carcinoma in situ, 40 (20.3%) had invasive carcinoma and 32 (16.3%) had atypical hyperplasia of the epithelium.

TABLE III
SUMMARY OF TABLES I AND II

Class of Smear	Cervicitis, Chronic	Atypical Hyperplasia	Carcinoma In Situ	Invasive Carcinoma	Total
Class III	50	29	46	40	145
Class IV	8	3	21	20	52
Total	58	32	67	40	197

TABLE IV
CLINICAL IMPRESSION

	No Pathology	Benign Pathology	Questionable Malignancy	Obvious Malignancy	Not Stated	Total
Carcinoma In Situ	33	22	7	1	4	67
Invasive Carcinoma	4	7	10	19	0	40
Total	37	29	17	20	4	107

The clinical impression (Table IV) of 55 (82.1%) of the 67 patients with carcinoma in situ was that the cervix was benign, and that only 8 (11.9%) appeared to be malignant or questionably malignant. Malignancy was obvious or suspected in 29 (72.5%) of the 40 patients with invasive carcinoma, but the cervix appeared benign in 11 (27.5%) of this group, all of which had microscopic evidence of invasion.

TABLE V
AGE AT TIME OF DIAGNOSIS

Age	Carcinoma In Situ	Invasive Carcinoma
19	1	0
20-24	6	1
25-29	5	1
30-34	11	2
35-39	11	5
40-44	6	4
45-49	4	3
50-54	3	2
55-59	0	2
60-64	3	9
65-69	2	3
70-74	2	3
75-79	1	1
80-84	0	2
Not Stated	12	2

As noted in Table V, one of the patients in the carcinoma in situ group was 19 years old, 11 (16.4%) were between the ages of 20 to 29 and 34 (50.7%) were below the age of 40. In the invasive group, one patient was 23 years of age, and 8 (25.8%) were below the age of 40 years.

TABLE VI
MARITAL STATUS

Status	Carcinoma in Situ	Invasive Carcinoma
Single	4	1
Married	53	28
Widowed	2	6
Divorced	1	0
Unknown	7	5

TABLE VII
PARITY

Parity	Carcinoma in Situ	Invasive Carcinoma
Nulliparous	9	4
Parous	41	26
Unknown	17	10

As shown in Table VI, 56 (83.6%) and 34 (85%) of the patients with carcinoma in situ and invasive carcinoma respectively were married, divorced or widowed, but 4 (6%) and 1 (2.5%) were unmarried. Also (Table VII), 41 (61.2%) with carcinoma in situ and 26 (65%) with invasive carcinoma were parous, but 9 (13.4%) and 4 (10%) respectively were nulliparous.

Discussion

Since the advent of exfoliative cytology, the diagnosis of preclinical carcinoma of the cervix has increased significantly. One group[1] reported that over a 10 year period the number of pre-clinical carcinomas of the cervix detected with the aid of cervical smear was five time greater than those diagnosed by biopsy alone.

It should be reiterated that the cytological smear is not a diagnostic procedure, but simply an effective method of screening pa-

tients rapidly and inexpensively. A positive smear merely indicates that there are cells present which have been interpreted as being abnormal and that further histologic investigation is indicated. Usually the higher the class reported, the higher is the incidence of carcinoma. For example, Soule and Dahlin[1] reported that carcinoma was found in 53% of the Class III group, 88% of the Class IV, and 99% of the Class V group. The results in our own small series were 45.5% and 79% respectively, with no Class V having been reported during this three year period.

Atypical hyperplasia of the cervical epithelium was responsible for abnormal cells in 16.2% of the patients in this survey. Although atypical hyperplasia per se is not believed to be malignant, a study by McKay et al[2] emphasizes the importance of the detection of this pathological entity. In a ten year follow-up study they found that 3.8% of those having atypical hyperplasia progressed to either carcinoma in situ or invasive carcinoma of the cervix. They also reported that atypical hyperplasia existed with carcinoma in 32.5% of their cases. This indicates 1, that these patients should have an adequate initial histologic diagnosis, and 2, that they should be followed closely for the development of carcinoma.

Thus far, the discussion has been confined to those patients having pathological entities to explain their positive smears. Those patients, however, who have no histologic atypicalities are categorized as having false positive smears. These have been reported ranging from 9% (4) to 23% (7) and most have occurred in the Class III group. In this series 58 (29.5%) of the 197 patients proved to have false positive smears with 50 (25.4%) occurring in the Class III group. Punch biopsy was the only diagnostic method used for 33 (56.9%) of these patients with false positive smears. If cold knife conization had been utilized, the number of false positive smears might have been reduced by demonstrating abnormal changes in other portions of the cervix. These false positive results may be due to 1, transient changes of the epithelium due to infection; 2, improper technique in obtaining, preserving or staining the smears; 3, errors in interpretation; and 4, inadequate specimen for histologic diagnosis. False negative results have been reported to occur in approximately 10%[3] of the cases. If repeated smears are done annually, however, the margin of error decreases significantly. Needless to say, an ulcerated or necrotic lesion on the cervix should be examined by biopsy since a smear is often negative. This is due to the fact that cancer cells may be buried under the exudate usually found on the surface of such lesions.

It is becoming increasingly evident that exfoliative cytologic studies should be performed on every woman reaching adulthood. It is certainly evident that clinical impressions of the cervix cannot be relied upon for detection of all carcinoma. This is shown in a series presented by Carter et al,[3] and in our own small series, whereby 88.5% and 82.1% respectively of the patients with carcinoma in situ had clinically benign-appearing cervices. Also, since a certain percentage of cases of invasive carcinoma are not clinically evident (Table IV), it appears advisable to do cytological studies on all patients having elective hysterectomies. It is difficult to set an age limit for screening purposes. In our series one patient with carcinoma in situ was 19 years of age and one with invasive carcinoma was 23. Also, 12 (17.9%) with carcinoma in situ were under 30 years of age. Although this survey in not primarily a statistical study of carcinoma in situ in this community, the statistics reported here are comparable to those of larger surveys. For instance, Carter et al[3] reporting on 275 cases of carcinoma in situ found that 19.6% of these patients were under 30 years of age.

Although the majority of women having carcinoma of the cervix are married and are parous, unmarried and nulliparous women also develop this entity.

Summary:

1. Local survey of 22,773 cervical cytologic

examinations was made in the laboratories of the Columbia Hospital of Richland County, the South Carolina Baptist Hospital and the Providence Hospital during the calendar years of 1960, 1961, and 1962.

2. Of 197 patients with positive smears, 34% had carcinoma in situ and 20.3% had invasive carcinoma involving the cervix, and 16.2% had atypical hyperplasia of the cervical epithelium.

3. The cervix appeared clinically benign in 82.1% of the patients having carcinoma in situ. Eleven patients in the invasive group also had benign appearing cervices.

4. False positive smears were found in 29.5% of the patients in this series. The majority (25.4%) of these occurred in those smears interpreted as being Class III. This percentage might have been reduced by adequate histologic investigation.

5. All women reaching adulthood should have exfoliative cytological studies regardless of age, parity, or marital status.

Acknowledgement

I wish to express my appreciation to the Departments of Pathology of the Columbia, Baptist, and Providence Hospitals of Columbia, South Carolina and to the local physicians for the cooperation which made this survey possible.

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Hematocrit changes under hyperbaric oxygen, Julian T. Buxton, J. Manly Stallworth, Gilbert B. Bradham, (Charleston). Amer Surg 30:18-22, Jan. 1964.

The study of hematocrit changes under hyperbaric conditions was made in an attempt to define the mechanism of oxygen toxicity which occurs at high atmospheric pressures. Six groups of anesthetized dogs were studied. One group served as control in one atmosphere, one group was compressed at 3 atm oxygen; a third group was compressed at 3 atm breathing oxygen at hyperventilated rates via a Bird respirator; a fourth group, splenectomized 6 weeks earlier, was subjected to 3 atm oxygen; a fifth group under 3 atm oxygen was given THAM prior to compression; and the last group under 3 atm pressure was given THAM and sodium bicarbonate prior to compression. Each animal had blood samples drawn through femoral artery and vein catheters for hematocrit determinations at hourly intervals.

In the dogs subjected to 100 percent oxygen at 3 atmospheres, a marked hematocrit rise occurred immediately. This effect did not occur in control animals, splenectomized dogs, or in those subjected to buffering agents or respiratory alkalosis. This implicates contraction of the spleen which is probably due to a stress response stimulated by a tissue hypercarbia. These data suggest that metabolic and hormonal changes occur quickly in the presence of hyperbaric oxygen even at the clinical range of 3 atmospheres. That these changes occur should stimulate further investigation of other physiological parameters at these pressures.

Termination of Dietary Treatment for Phenylketonuria—P. R. Vandeman. Amer J Dis Child 106: 492 (Nov) 1963.

Two patients with phenylketonuria were treated with phenylalanine deficient diets from the ages of five months and one month. Treatment was terminated at the age of three years, and developmental follow-up showed no evidence of deterioration through the ages of 6½ and 7½ years. It would appear that dietary treatment for phenylketonuric patients (treated from an early age) may be terminated at an age of about three to four years with relatively little risk of further damage to mental development.

THE LONG ARM ENTEROTOMY COLOTOMY DECOMPRESSOR IN THE SURGICAL MANAGEMENT OF INTESTINAL OBSTRUCTION

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G. B. HODGE, M. D.
W. C. HAGGERTY, M. D.

Intestinal obstruction is a condition frequently requiring surgical management. The conservative treatment usually consists of intubation, colonic irrigation and replacement of fluids and electrolytes. In those cases with a complete mechanical obstruction, surgical intervention is imperative in order to avoid strangulation, gangrene, and severe metabolic derangement.

In the majority of cases requiring surgical correction, one encounters long segments of either small or large bowel distention making closure of the abdominal wall following release of the obstruction extremely difficult. Various means of decompression have been used; however, because of the marked degree of involvement, adequate decompression through the usual measures is only partially effectual. In view of this problem, the senior author developed an enterotomy colotomy decompressor which has been previously described.[1] This instrument consists of a metal tube measuring 19¾ inches in length, having an outer and inner tube which is attached permanently to a special two-way stopcock that provides for decompression of the distal and proximal segments of the intestinal lumen. (Figs. 1, 2) The entire length of the small bowel can be very readily decompressed with this instrument by sleeving the distended bowel on the instrument. (Fig. 3) We feel that this simple instrument, has modified the usual post-operative course in patients with marked mechanical intestinal obstruction.

Read before the South Carolina Surgical Society, Charleston, S. C., March 29, 1963.

In a recent review of 100 unselected cases of intestinal obstruction taken from the records of the Hodge Clinic and the Department of Surgery of the Spartanburg General Hospital from September, 1958, to December, 1960, 12 of the patients required enterotomy for decompression.

Of the entire group, eight were treated non-operatively. There were four records in this series which were not sufficiently detailed to be included in the study. Of the remaining 88 patients, 13.6 per cent comprised the series which will be reported in more detail.

In the 88 cases requiring operative intervention for intestinal obstruction, the ages varied from 2 weeks to 81 years. In those having enterotomy for decompression, the ages ranged from 5 weeks to 67 years, with an average age of 45.5 years. In the 12 patients requiring enterotomy, seven were females and five males.

The etiology of intestinal obstruction in this group may be classified as congenital, inflammatory, and mechanical. The most



Figure 1
The outer and inner tubes of the decompressor are engaged. The handle of the stopcock is in the neutral position.

common etiological factor in this series was post-operative, adhesive, agglutinate obstruction. Of the group requiring enterotomy, nine cases were due to mechanical obstruction incident to post-operative adhesions, and 30 per cent of these were subsequent to gynecological procedures. In addition to decompressive enterotomy, two cases required small bowel resection. Operative intervention was necessary in the immediate post-operative period (7 to 10 days) in 9 per cent of the total group studied. In five patients surgery for intestinal obstruction had been previously performed.

Case Reports

Case 1.—This 50 year old white female was admitted on May 15, 1960, complaining of intermittent episodes of epigastric and right upper quadrant abdominal pain associated with nausea and vomiting. She had associated anorexia, gaseous eructation and distention. She noted cramping and right lower quadrant abdominal pain and borborygmus. She had had a ruptured appendix at the age of 24. The pertinent physical findings were confined to the abdominal examination. The abdomen was distended, there was hyperperistalsis with borborygmus and moderate tenderness in the right upper abdominal quadrant. There was a mid-rectus operative scar and upon palpating this area, borborygmus and adherent loops of intestines were evident. On May 20, 1960, the patient had repair of a ventral hernia with lysis of adhesions of the small intestine which were densely adherent to the abdominal scar. A serous cyst of the right ovary was found at operation and this was resected. On the sixth post-operative day she developed abdominal distention, nausea and vomiting. Nasogastric intubation with suction was carried out and other supportive measures were instituted. A scout film of the abdomen revealed moderate distention of the small bowel and there was gas in the colon. In spite of intubation suction, a mechanical intestinal obstruction progressed and on June 4, 1960, a celiotomy was carried out. The jejunum and ileum were markedly dilated and the point of obstruction was found to be in the right lower quadrant where there was dense agglutination of the small bowel to the abdominal wall, cecum and ascending colon.

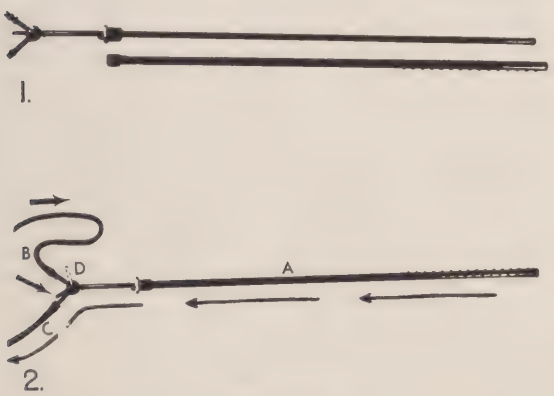


Figure 2

Outer and inner tube of the decompressor. By turning the outer tube in a counter clockwise direction it is disengaged from the inner tube. A. Decompressor tube for distal segment of intestine. B. Tube leading from proximal segment. C. Tube leading to suction apparatus. D. Stopcock to connect tube A or B to suction tube C.

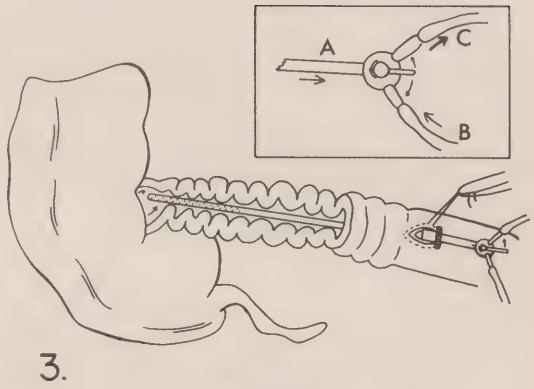


Figure 3

Distal segment of intestine telescoped on decompressor. Insert shows stopcock in neutral position.

A long arm tube enterotomy instrument was passed through the jejunum with complete decompression of the small bowel to the point of obstruction. Because of the intense inflammatory reaction involving the obstructed portions of the terminal ileum and right colon, it was necessary to resect the involved bowel and a side-to-side ileotransversostomy carried out. The patient had an uneventful post-operative course and was discharged from the hospital on June 19, 1960.

Comment: This case represents a patient with ventral hernia and post-operative adhesive partial obstruction following treatment of a ruptured appendix a number of years previously. Lysis of the bowel adherent to the ventral hernia resulted only in further post-operative agglutination of the involved bowel, necessitating a second operative procedure. The procedure was greatly facilitated by the rapid and prompt decompression of the

markedly distended small bowel, thus making the further operative procedure considerably easier. The abdominal closure was without difficulty as a result of the decompression.

Case 2.—This 44 year old white male was admitted on Dec. 23, 1958, with acute cramping, sharp abdominal pain with nausea, vomiting, and abdominal distention of 12 hours duration. Eight months previously, he had a perforated peptic duodenal ulcer for which a subtotal gastric resection of the Billroth II, Hofmeister type of anastomosis was performed. There was marked abdominal distention with generalized tenderness, rebound tenderness and muscle guarding, particularly in the right upper and lower quadrants of the abdomen. Peristalsis was hyperactive. A scout film of the abdomen demonstrated distended loops of small bowel in the mid-abdomen and some gas in the colon, with findings suggestive of an incomplete mechanical obstruction. The hemoglobin was 14.2 gm, white blood count 12,100, packed cell volume 45 per cent; differential —82 segs, 4 bands, 11 lymphocytes and 3 monocytes.

On Dec. 23, 1958, this man had an exploratory laparotomy through a right rectus muscle splitting incision, and the entire lower jejunum and ileum appeared to be distended. Obstructive adhesive bands between the jejunum, ileum and anterior abdominal wall were divided. Because of gross distention and difficulty in performing the abdominal closure, a decompressive enterotomy in the mid-jejunum proximal to the site of obstruction was done. The entire small bowel was adequately decompressed, and the abdomen was closed. The patient made an uneventful recovery except for wound infection, which responded to open drainage, penicillin, streptomycin, chloramphenicol, and saline compresses. The patient was discharged on Jan. 13, 1959.

Comment: Adhesive intestinal obstruction occurred subsequent to surgery for a perforated peptic duodenal ulcer. Because of difficulty in closing the abdomen due to distended loops of ileum and jejunum, it was necessary to perform a decompressive enterotomy proximal to the site of obstruction and the operative procedure was rapidly terminated.

Case 3.—A 39 year old white female was seen in consultation with a gynecologist on Nov. 2, 1959, with a history that one week previously she had a total abdominal hysterectomy and appendectomy performed for uterine fibromyomata. Following operation, she developed moderate abdominal distention and on about the fifth post-operative day became markedly distended and vomited profusely. She was an acutely ill woman with great abdominal distention and generalized abdominal tenderness. A few peristaltic tinkles were audible. Rectal examination disclosed fecal material present in the rectal ampulla. Scout films of the abdomen showed large distended loops of small bowel consistent with acute mechanical obstruction. The patient was treated with a nasogastric suction tube; fluid and electrolytes were replaced. On Nov. 4, 1959, a laparotomy was performed through the previous suprapubic abdominal incision, and this was extended superiorly. Upon entering the abdomen, the small intestines were tremendously distended, and approximately 1000 ml of blood was present in the peritoneal cavity. There was a large organized hematoma in the pelvis, and the terminal ileum was kinked and adherent to the under-surface of the mesentery, causing an acute obstruction in the region of the terminal ileum. Lysis of adhesions by sharp dissection was done. Enterotomy was performed by placing a purse-string suture of 000 silk in the mid-jejunum, and the long arm enterotomy tube was passed proximally and distally into the intestinal lumen. Decompression was dramatic and following withdrawal of the instrument, the purse string suture was drawn tightly. A drain was inserted beneath the fascia and brought through the lower end of the wound. Following operation, the patient received adequate fluids, electrolytes, and antibiotics and made an uneventful recovery and was discharged from the hospital on Nov. 21, 1959.

Comment: The patient developed acute mechanical intestinal obstruction five days following total abdominal hysterectomy. She was acutely ill and exhibited considerable abdominal distention due to a significant degree of obstruction, but decompressive enterotomy adequately relieved this patient's obstruction. A more accurate determination of fluid and electrolyte deficits was made by charting the amount of fluid aspirated from the abdominal cavity and intestinal lumen. Immediate decompression of the small bowel allowed for rapidity and early termination of the operative procedure in this poor risk, debilitated, toxic patient who was in fluid and electrolyte imbalance.

Case 4.—A 25 year old colored male was admitted on Sept. 29, 1960, with gunshot wounds of the abdomen and left shoulder. On physical examination there was evidence of an acute abdominal emergency. Following preparation with a nasogastric tube, blood, electrolyte and fluid replacement, the patient underwent laparotomy. Perforations of the stomach and diaphragm, and laceration of the left lobe of the liver were found. The

damaged structures were sutured. On Oct. 6, 1960, he developed abdominal distention, crampy, generalized abdominal pain, fever, with absence of peristalsis. Scout films of the abdomen demonstrated gross distention of proximal loops of small bowel due to complete mechanical obstruction. There was x-ray evidence of fluid in the left pleural cavity. Thoracentesis was done and 75 ml of purulent fluid were aspirated from the left pleural cavity. Hemoglobin was 10.6 gm. Despite heavy doses of antibiotics, consisting of terramycin, streptomycin, penicillin and chloramphenicol and satisfactory nasogastricenteric Levin tube drainage, the temperature rose to 39.5° C. The patient was toxic, and his condition began deteriorating.

This man had an incomplete small bowel obstruction with a left pyopneumothorax. Exploratory laparotomy was done through the original paramedian incision, and a foul-smelling, purulent exudate with several post-operative adhesive bands involving the lower jejunum and ileum was found. Adhesions were released by sharp dissection, and purulent fluid was aspirated from the abdominal cavity. Because of gross distention of the intestinal loops, a decompressive enterotomy was done and approximately 2500 ml of gas and intestinal fluids were evacuated by the long tube enterotomy decompressor. Following completion of the abdominal procedure, open thorocotomy drainage through the left sixth interspace was performed, and a chest drainage tube was connected to an underwater seal. During the post-operative period recovery from the intestinal obstruction was relatively uneventful; however, hospitalization was prolonged due to empyema involving the left lower cavity. He was discharged on Nov. 6, 1960.

Comment: This man developed an adhesive intestinal obstruction following gunshot wound of the abdomen with damage to several viscera. He had a secondary procedure performed during his hospital stay as a result of a mechanical intestinal obstruction. At the time of surgery, his condition was toxic and deteriorating and he was a poor operative risk. However, decompressive enterotomy afforded rapid evacuation of contents from the distended loops of small bowel and eliminated the difficulty of attempting to close the abdomen in the face of large distended loops. of intestines.

Summary and Conclusions

1. Eighty-eight unselected cases of mechanical obstruction of the small bowel were collected from the records of the Hodge Clinic and the Spartanburg General Hospital during 1958 - 1960, and 12 of these patients required long tube decompressive enterotomy.

2. Cases of mechanical intestinal obstruction illustrate the efficacy with which the enterotomy decompressor completely evacuated the intestines. The larger surface suction area of this nontraumatic instrument allows the operator to thread larger segments of bowel, thereby enhancing the rapidity of evacuation of intestinal contents. The operative procedure is greatly facilitated by the prompt decompression of markedly distended small bowel, thus making surgery and abdominal closure considerably easier. A more accurate determination of fluid and electrolyte losses from the intra and extra-cellular compartments can be calculated and existing deficits corrected.

3. This instrument has proved useful and valuable in decompressing obstructed loops of small intestine in the poor risk, toxic and debilitated patient.

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Instrument may be obtained from G. B. Pilling & Company, Philadelphia, Pa.

IDIOPATHIC HEMORRHAGIC PERICARDITIS

Report of a case and a possible relationship to chronic constrictive pericarditis.

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Although idiopathic pericarditis is a relatively common disease and may produce a pericardial effusion, there are very few reports of cases in which a pericardial tap has been performed. Williams[1] *et al*, in 1960 were able to find only 22 cases, including their own, in which pericardial taps had been done. Of these, 14 were hemorrhagic.

Idiopathic hemorrhagic pericarditis recently has been considered a cause of chronic constrictive pericarditis. Although in the past constrictive pericarditis was usually thought to result from tuberculosis, Effler[2] reported on 26 patients operated upon for chronic constrictive pericarditis and found tuberculosis to be the cause in only two. No other etiology was discovered, but viral studies were not reported. He stated that in most of the 26 cases, residual blood elements were noted within the pericardial sac at the time of surgery, suggesting that the original process was hemorrhagic pericarditis of unknown cause.

Our purpose is to report a case of idiopathic hemorrhagic pericarditis in which viral studies were negative and to discuss the sanguineous character of the pericardial effusion and a possible relationship with chronic constrictive pericarditis.

Case Report

A 43 year old white man was admitted to Great Lakes Naval Hospital because of substernal, pleuritic chest pain which radiated to both shoulders. The pain had developed 2 weeks prior to admission and was associated with a cough, malaise, and low grade fever. One day prior to admission the chest pain increased and temperature became elevated to 102° F. With the fever there were profuse sweating and chills. A chest x-ray film taken one month earlier was considered normal. The film taken on admission revealed marked enlargement of the cardiac silhouette, most likely on the basis of pericardial effusion (figure 1).

The patient was a mildly obese male in acute distress with chest pain. The pulse rate was 100 per minute and the oral temperature was 99.6° F. His blood pressure was 120/80 mm Hg with 12mm of paradoxical pulse. His height was 75 inches and weight was 246 lbs. The neck veins were pulsating and distended when the patient was elevated to an angle of 45 degrees. The chest was clear to auscultation; however, Ewart's sign was present. Cardiac examination revealed the point of maximum impulse to be diffusely palpable outside the mid-clavicular line within the fifth intercostal space. The heart tones were faint and a to-and-fro pericardial friction rub was audible. The liver was not palpable, but a hepato-jugular reflux was present. There was no pedal edema.

After admission to the hospital the chest pain lessened. An ECG revealed S-T elevations, T wave changes, and reduced voltage compatible with pericarditis (figure 3). On the following day the pulse pressure decreased; the blood pressure changed from 120/80 to 120/100.

The neck veins became more distended and venous pressure was found to be elevated to 230 mm of water. The 12 mm paradoxical pulse persisted. A pericardial aspiration was performed and 120 ml of bloody fluid which did not clot was removed. The hemoglobin of this fluid was 3 grams 100/ml and the hematocrit was 8 volumes per cent. The patient remained febrile for 3 days and was treated with penicillin. His condition improved, but on the fifth hospital day he developed atrial fibrillation (figure 3). He was digitalized and the electrocardiogram reverted to a normal sinus rhythm, with S-T segment

The opinions and views expressed are those of the authors and are not to be construed as official or necessarily reflecting those of the Medical Department of the United States Navy or the Naval Service at large.

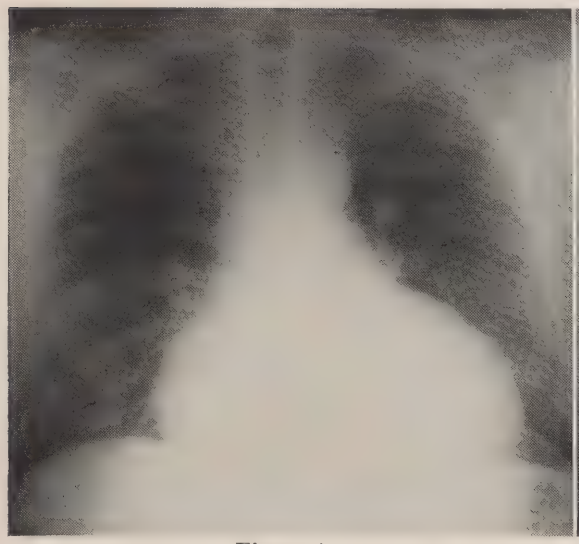


Figure 1

Admission chest x-ray film showing an enlarged cardiac silhouette compatible with pericardial effusion.

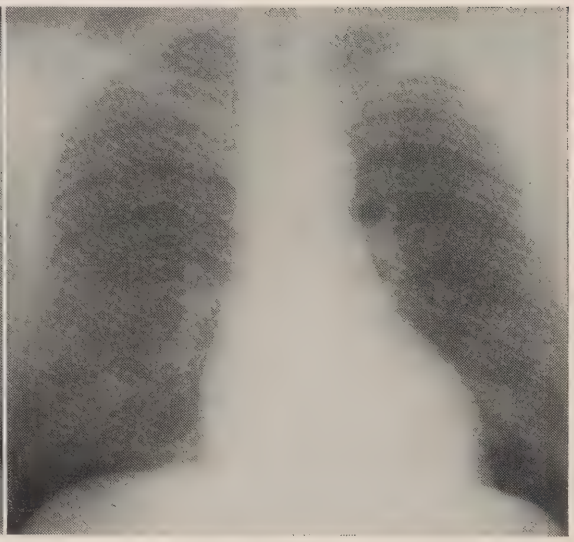


Figure 2

Chest film showing the return of normal cardiac silhouette.

changes, and persistent T wave inversion (figure 3). A chest x-ray film showed that the cardiac silhouette had returned to normal (figure 2). After 6 weeks the patient was asymptomatic and able to walk about without difficulty.

Laboratory data on admission were: hemoglobin 11 grams; white count was 12,600 per cu mm with 76% neutrophils. The sedimentation rate was 64 mm per hr. and the C-reactive protein, 4 plus. Three serum glutamic oxalacetic transaminase levels did not rise above 27 units. Serum lactic dehydrogenase was 400 units. Serial antistreptolysin 0 titers did not rise above 50 units. Three L E preparations were negative. A serum latex fixation test was negative. Cultures of the sputum and pericardial aspirate for routine bacteria, fungi, and mycobacterium tuberculosis were negative. Histoplasmin, coccidioidin and blastomycetin skin tests were negative, but a P P D #2 was positive. Serum and pericardial fluid showed no virus growth after two blind passages on three different culture lines (monkey kidney, H. Ep-2, and human embryonic lung). Acute and convalescent serum failed to produce any serologic response to Coxsackie viruses (B1, B3, or B5).*

Discussion

This case of hemorrhagic pericarditis was considered to be of the idiopathic variety on the basis of negative bacterial, fungal, and viral studies. The patient showed typical chest pain, pericardial friction rub and the characteristic, electrocardiographic pattern of pericarditis.

In similar cases the hemorrhagic character of the pericardial effusion ordinarily does not become evident before 10 days. Reid[3] concluded that the effusions are usually serous during the first 10 to 14 days of the illness and then become sanguineous later in the course of the disease. Our case lends support

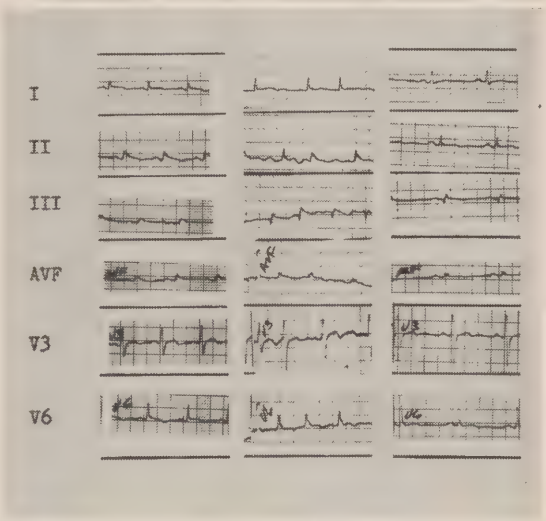


Figure 3

Serial electrocardiograms revealing changes compatible with pericarditis, the development of atrial fibrillation, and a return to sinus rhythm with persistent T wave changes.

*Naval Medical Research Unit No. 4, U. S. Naval Hospital, Great Lakes, Ill.: Max J. Rosenbaum, Ph.D., Chief, Virology Division.

to this concept. According to Goodman,[4] the pathologic process in idiopathic pericarditis consists of early organization of the fibrinous exudate with extensive capillary proliferation on the epicardial and pericardial surfaces. This process is maximal at 10 to 15 days and correlates with the bloody character of the pericardial fluid seen at that time.

It is of interest that our patient developed atrial fibrillation. Generally, atrial arrhythmias develop with greater frequency in chronic pericarditis and constrictive pericarditis and are usually attributed to subepicardial fibrosis and possibly to prolonged elevation of atrial pressures. James[5] has indicted inflammation of the sinus node as a cause of atrial arrhythmias in pericarditis. He reported on 38 patients with pericarditis of whom 26 had documented atrial arrhythmias which he considered due to sinus node involvement.

Intensive histologic and bacteriologic studies in patients with constrictive pericarditis have failed to establish the etiology in many cases.[6] The finding of a sanguineous effusion in a high percentage of those tapped for idiopathic pericarditis,[1] and the frequent occurrence of residual blood elements seen at the time of pericardectomy for constrictive pericarditis,[2] support the role of idiopathic hemorrhagic pericarditis in the etiology of some cases of constrictive pericarditis.

Summary

A case of idiopathic pericarditis with hemorrhagic effusion is discussed. The relatively frequent occurrence of a sanguineous effusion in this disease is emphasized and the possible relationship to the development of constrictive pericarditis is considered.

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Tuberculosis in South Carolina

Seven hundred and forty *new active* tuberculosis cases were reported in 1963. Of these, 288 or 39% were in whites and 452 or 61% were in Negroes.

Out of each 100 *new active* cases of tuberculosis reported during the year the ratio of white males to white females was 65 to 35, and in Negroes this ratio was 62 to 38.

The overall *new active* tuberculosis incidence rate per 100,000 population was *30.4 in 1963* compared to *33.5 in 1962*. Comparable incidence rates for whites were *18.0* in 1963 and *18.2* in 1962, and for Negroes *54.3* in 1963 and *62.2* in 1962.

FORTY-ONE (41) COUNTIES ARE NOW PARTICIPATING IN THE SPECIAL PROJECT AIMED AT THE ERADICATION OF TUBERCULOSIS.

Basically this is a five point program:

1. Placing all known active cases of tuberculosis under prompt, scientific and continuous treatment.

2. Immediate examination of all close contacts of known active cases of tuberculosis.

3. Early examination and disposition of persons classified as tuberculosis suspects.

4. Administering the prophylactic drug Isoniazid to infants and pre-school children with positive tuberculin skin tests, and to selected household contacts of active tuberculosis cases.

5. Arranging for all known tuberculosis cases to be under adequate medical and nursing surveillance.

DIVERTICULITIS OF THE CECUM

Report of two cases

WILLIAM H. PRIOLEAU, M. D.

Medical College of South Carolina and the Roper Hospital, Charleston, S. C.

Diverticula occur predominantly in the left colon and to a lesser extent in the transverse colon. Complications are quite common. They assume the form of bleeding, perforation, abscess, constriction and fistula formation. In the right colon, the incidence of diverticula is relatively infrequent, being reported as 1.5 to 2%.[1] They occur in small numbers or singly. They are usually silent. Complications are only infrequently reported. In a survey of the literature in 1961, Rodkey and Herman found 357 cases of surgically proven cases to which they added 14 of their own.[2] The complications in the right colon are in the nature of perforation with abscess, or an inflammatory mass. In a review of the literature in 1961 Bennett and Sands found no reported cases of severe hemorrhage, obstruction or fistula.[1] There are no characteristic symptoms of acute diverticulitis of the right colon. The clinical picture is one of an acute, or sub-acute, intra-abdominal inflammatory process. Diverticula occur at sites of developmental defects where blood vessels pierce the wall of the intestine. While the etiology is not known, there appears to be very little relationship to increased intraluminal pressure. In diverticula of the small intestines, Edwards hypothesizes that a peristalic irregularity is an important factor;[3] the same may apply to the formation of diverticula of the colon.

Operation for diverticulitis of the right colon is indicated by the presence of an acute inflammatory process. In early cases, according to the stage of development, treatment consists of excision or inversion with closure of the defect in the bowel wall, or drainage of the abscess, with or without cecostomy. In some cases in which there is an indurated mass, one cannot differentiate readily and safely between diverticulitis and carcinoma; under such conditions resection of the right colon is considered advisable. Bennett and Sands report 3 such cases treated successfully by right hemicolectomy.[1]

Case 1—(Courtesy of Dr. J. Manly Stallworth) White female, single, age 54 years, admitted May 12, 1959. P.I. onset 3 days ago with attack of general abdominal pain not accompanied by nausea or vomiting. The pain subsided only to recur on the day before admission. At this time there were nausea and localization of pain in the region of the umbilicus. P.H.—appendectomy at 20 years of age. At age 45 in August 1950, at time of subtotal thyroidectomy for a benign goitre, she had no gastro-intestinal symptoms. On a hospital admission in November 1962 for biopsy of a benign breast lesion, she had bouts of subxiphoid pain with gaseous eructations. X-ray examination of upper GI tract revealed a small hiatus hernia. At this time she was taking one grain of thyroid extract daily. She had had her menopause eight years ago.

Physical exam: Normally developed and nourished white female in acute abdominal pain. There was generalized abdominal tenderness with muscle spasm in the region of the umbilicus. X-ray examination showed a mild ileus. WBC 10,000 PMN, 74%. At operation through a right paramedian incision, the cecum and omentum were separated from a McBurney incision scar. Lateral to the cecum and adherent to the surrounding fat was a gangrenous diverticulum with a 1 cm base. The diverticulum was partially excised and a mushroom catheter was inserted into the cecum to serve as a vent. The postoperative course was uneventful. She was discharged in good condition May 24, 1959.

Case 2—White male, 63 years of age admitted August 2, 1956 complaining of right lower quadrant pain. The onset was on July 31 with diarrhea of four

hours duration. A game of golf the next day was followed by intermittent cramping pain and an elevation of temperature. The past history was irrelevant.

Physical exam: Normally developed and nourished white male with pain and tenderness in the right lower quadrant; no rebound tenderness. Rectal exam, negative. WBC 17,500. Preoperative diagnosis — appendicitis acute. Operation: A McBurney incision was extended medially. Omentum was freed from a hernia repair scar. The appendix was free and rudimentary. It was removed. Lateral to the cecum was a 5 cm firm mass. The cecum was partially mobilized. There was found a necrotic diverticulum surrounded by indurated fat. The stump of the diverticulum was inverted. A mushroom catheter was passed into the cecum through the stump of the appendix to serve as a vent. The immediate post-operative course was uneventful, however on the ninth day after operation, the patient went into shock. Clinical and x-ray findings indicated a left pulmonary embolus. He was placed on heparin, dicumarol and antibiotics. Subsequent x-ray exam. showed left mid lung haziness consistent with infarct. He was discharged in good condition on August 25, 1956.

Summary

1. The subject of diverticulitis of the right colon is briefly considered from the clinical aspect.

2. Report of two cases in which the diagnosis was made early and the operation could be limited to the care of the perforated diverticulum.

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Clinical manifestations and therapy of acute lead intoxication due to the ingestion of illicitly distilled alcohol—J. C. Crutcher. Ann Intern Med 59:707 (Nov) 1963.

Thirty-two episodes of lead poisoning observed in 27 patients from the ingestion of bootleg whiskey made in lead-containing pipes and automobile radiators are reported. Seven patients had lead encephalopathy manifested by delirium, drowsiness, convulsions, and coma associated with increased cerebral spinal fluid protein. Basophilic stippling in both peripheral blood and bone marrow, a hypochromic anemia, increased reticulocytes, and an occasional positive direct Coombs' test were the major hematological abnormalities. The gastrointestinal symptoms consisted of anorexia, nausea, vomiting, severe abdominal pain, and severe constipation, mimicking obstruction of the large bowel. These symptoms were of sufficient magnitude to cause surgical intervention in three patients in whom the diagnosis was not recognized. Initial albuminuria cleared during treatment in six patients of whom five had moderate azotemia. Indirect bilirubinemia greater than 1 mg% was seen in seven. Treatment with calcium ethylenediaminetetraacetate (CaEDTA) either 2 gm daily for 5 days, or 1 gm daily for 10 days resulted in the alleviation of the abnormal signs and symptoms in all of the patients. On therapy 24-hour urine lead excretion ranged in individual patients from 1.5 to 20 mg per 24-hour urine volume. No toxic effects of a CaEDTA therapy were noted in these patients. In adult patients with lead poisoning CaEDTA therapy remains an effective and safe method.

Prevention of dental arch collapse, by R. F. Hagerty, E. B. Andrews, M. J. Hill, B. P. Mendelson, S. H. Karesh, J. M. Lifschiz and D. R. Swindler, (Charleston). Angle Orthodont 34:53-57, Jan., 1964.

This study is in the nature of a progress report attempting to evaluate the effectiveness of the palatal bar in preventing dental arch collapse. Dental arch collapse appeared to be less pronounced in this small series of Type III and Type IV cases in whom palatal bars had been used than in the subjects in the reported study in whom the bars were not used. The groups studied, however, were not equal. The cases in this study had no palatal surgery; the lip surgery was carried out by one plastic surgeon, and the dental study models were taken before age two, rather than after age seven.

It is well known that correction of dental arch collapse can be achieved if skilled orthodontic management is provided early enough. However, such treatment is unavailable to a large part of the cleft palate population. When available, it is prolonged and expensive. For this reason it is felt that any simple surgical measure which will prevent or even reduce deformity is well worth the time and effort necessary to its development.

AN EVALUATION OF T3 RESIN UPTAKE

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Introduction

The PBI determination has proved to be the most valuable single laboratory aid to the diagnosis of thyroid function. A determination of I^{131} uptake by the thyroid is probably just as reliable, but the latter test is expensive, inconvenient to the patient and entails more incipient risk to the patient than does PBI.

From the clinician's standpoint, PBI's have the disadvantage of being subject to Hg and I_2 contamination. From the laboratories' standpoint, PBI analyses are probably the most expensive in technician hours. In our laboratory about 1/3 to 3/4 technician hour for each determination is required, depending on the method used and the number of determinations.

The development of the T3 red cell uptake test[1] eliminated the factors of heavy metal and I_2 contamination, but there seems to be considerable overlap of derived values corresponding to the three primary thyroid states and the procedure is time consuming and generally expensive. Also, there is an instability of the affinity of T3 for the red cell, which produces variable results with minor changes in washing techniques. The use of resin in lieu of red cells[2] eliminates the necessity of centrifuging as well as hematocrit determination and has the advantage of giving a uniform component for distribution of T3, thus eliminating a variable. The most advanced T3 resin uptake methods require about 10 min. for each determination.

With increasing awareness of the value of the PBI test has come the common use of PBI as a "routine screening test" comparable to urinalysis and blood counts. As a result, many laboratories have been faced with backlogs of PBI's several months or years old.

The use of T3 resin uptake (T3RU) as a screening test would enable laboratories to prevent these backlogs and give better service. Indeed, in those rare cases of thyroid disorder where "stat" reports are justified, the laboratories can have results within an hour and a half of receipt of the sample.

Methods

T3RU determinations are essentially triiodothyronine saturation tests made on serum (or plasma). The principle is based on the assumption that the hypothyroid patient would have a low degree of hormone saturation of the hormone-binding protein (alpha globulin), whereas the hyperthyroid patient would have a high degree of saturation. Practically, the tests consist of adding measured quantities of ion-exchange resin and radioactive triiodothyronine (T3) to aliquots of serum, mixing for a period of time, measuring the rate of gamma emission in a well-type counter, washing the resin, and making a second count on the protein-free resin. The percent of uptake is determined by dividing the first count into the second and multiplying by 100.

The principal modification of the preceding method involves taking an aliquot of the serum (in lieu of washing the resin) and making the second reading on this aliquot. Assays using this technique are commonly referred to as TBI (thyro-binding index). Low values of TBI are encountered in hyperthyroid and high values in hypothyroid pa-

tients. Conversely, high T3RU values are found in hyperthyroids and low values in hypothyroids. In either of these methods pooled serum standards are essential as controls.

Factors Producing Abnormal Results Which Are Not Related To The Thyroid State

Conditions producing values similar to those encountered in hypothyroids are pregnancy, estrogen therapy,[3] hyperproteinemia (above 8.8g/100 ml total protein) and administration of some anovulatory drugs (ie: norethnodrel).[4] Generally, the values of T3RU in pregnancy are lower than those encountered in hypothyroids. It has been the observation of this laboratory that pediatric patients below 3 years have consistently low values.

Elevated values not related to the thyroid state are reported to occur in anticoagulant therapy, nephrosis, severe metastatic malignant disease, severe pulmonary insufficiency with CO_2 retention, paroxysmal atrial arrythmias, and butazolidine or salicylate therapy.[3] In the 261 patients studied at this medical center, T3RU elevations not associated with thyrotoxicosis and having a well defined etiology were encountered only in hypoproteinemia (less than 4.3g/100 ml total protein) and metastatic carcinoma.

One should not overlook the possibility that the previously mentioned factors in combination with thyrotoxicosis or myxodema may result in normal T3RU's. For instance, this laboratory has found that combinations of pregnancy with hyperthyroidism may produce normal values. We also suspect that myxedema secondary to anterior pituitary failure may produce misleading results, but have not observed a sufficient number of cases of this sort to substantiate this suspicion. However, no other investigators have found that endocrinopathies other than those associated with the thyroid directly influence T3RU.

Values and Reproducibility of Results

The normal results of T3RU or TBI will depend upon the method used and have to be established by the laboratory designing the method. For this reason it is probably advisable for laboratories serving small communities to purchase assay kits (available from Squibb, Abbott, *et al.*).

One method of approaching a standard conformity of results among different laboratories is to divide the percent uptake of the pooled serum standard into that of the unknown; however, the ranges may still not conform.

The range of euthyroid patients in most T3RU methods is about 10% uptake and the reproducibility is about ±1%.

Evaluation Relative to PBI

Simultaneous determinations of PBI's and T3RU's on 261 patients and subsequent observations on the clinical impressions and I^{131} uptakes by the thyroid (done on about one half the patients with abnormal PBI's) indicated that the T3RU gave three times fewer misleading results than the PBI. Excluded from the data were known cases of Hg or I_2 contamination, pregnancies, pediatric patients and patients with hypo- and hyperproteinemia, those on estrogen therapy, and those with metastatic carcinoma.

The objection may be enunciated that more variables influence T3RU than PBI; however, it should be recalled that factors other than hypoproteinemia, metastatic carcinoma and thyrotoxicosis rarely produce elevation in T3RU. It is also pertinent to mention that norethynodrel, hypoproteinemia, dilantin-type drugs and pregnancy influence both PBI and T3RU.

In conclusion it may be said that T3RU has eliminated the factors of Hg and I_2 contamination which are major interfering factors in PBI analyses; it is less time consuming than a PBI determination and, therefore, less expensive to the patient. In our opinion, it has a reproducibility and clinical correlation reliability equal to or exceeding PBI. Also, in contrast to earlier observations, this laboratory has found that serum is fairly stable and will maintain its T3RU level at least for 48 hrs. at room temperature, thus enabling fairly prompt shipment to laboratories.

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Prevention of adverse emotional attitudes in families of chronically handicapped children. R. Ramsey Mellette, Jr. (Charleston). Southern Med J 57:267-269, Mar. 1964.

The busy physician often fails to communicate in an easily understandable, supportive, and compassionate manner with the parents of chronically handicapped children. Diagnoses and interpretations are often presented, without empathy, in medical jargon which has little or no meaning for parents. The results are often the arousal of fears, anxieties, resentments, and other prolonged pathological emotional reactions which aggravate problems and interfere with optimal benefits from therapy. The most effective assistance to the child and family depends not only on the diagnosis and treatment of the disability but also on such factors as: explaining to the family in clearly understandable language the medical findings and recommendations, handling of prolonged pathological emotional reactions of parents, preparation for handling environmental and physical sequelae, knowledge of available resources, follow-up of supportive therapy and interpretative visits, consultation with specialized colleagues, continuing self-education, supporting the development of community resources, and cognizance of the fact that emotional problems may be superimposed on physical problems. "The goal of any physician who treats the chronically handicapped child should be optimal utilization of the child and family's potentials for the healthy adaptability to the realities of life."

Fetal distress. Paul B. Underwood, M. D., Lawrence L. Hester, M. D. and Joseph H. Cutchin, Jr., M. D. (Charleston) J Med Ass Georgia 52:461, 1963.

Fetal distress prior to the onset of labor, as seen in the diabetic, pre-eclamptic, hypertensive, or the erythroblastotic fetus, is the most difficult to diagnose and manage. In these cases, a more precise test is needed to determine the point at which the fetus would be under less jeopardy if delivered. The best approach to this problem appears to be through placental function evaluation which has been attempted in several ways: time required for maternal intravenous atropine sulfate to produce a fetal tachycardia; number of minutes the placenta can maintain adequate fetal oxygenation, as determined by fetal heart rate, with maternal inhalation of 10 per cent oxygen; placental transfer of radioactive sodium; and maternal urinary determinations of placental derived estriol. Once perfected, the decision to terminate pregnancy can be based on a scientific fact and not on nebulous theories, inaccurate observations, and the influences of a few personal cases.

Fetal distress during labor is indicated either if the fetal heart rate is more than 180 or less than 100 per minute or if meconium stained amniotic fluid is present in a vertex presentation. In our small series, we observed a 4.7 per cent incidence of fetal distress resulting in a 9.7 per cent fetal mortality with meconium alone, 33.3 per cent with bradycardia alone, and 37.5 per cent with both present.

Dental arch collapse in cleft palate, by R. F. Hagerty, E. B. Andrews, M. J. Hill, C. E. Calcote, S. H. Karesh, J. M. Lifschiz and D. R. Swindler. (Charleston). Angle Orthodont 34:25-36, Jan., 1964.

No dental arch collapse was demonstrated in submucous, Type I, or Type II postoperative cleft palate patients. Dental arch collapse, as indicated by area measurement of the anterior palatal quadrants, was seen in almost all Type III postoperative patients on the cleft side. With increasing palatal size there is an absolute increase in asymmetry between these quadrants, but the relation between the cleft and non-cleft remains the same as shown by the linear regression equation. Dental arch collapse, as indicated by area measurements of related superimposed anterior arch segments, was seen in all Type IV postoperative patients.

Dental arch collapse in fifteen unoperated unilateral complete cleft palate patients (lip repaired at age 12 months) was found to be more marked than that found in a group of similar patients following both palatal and lip surgery. On the other hand, in six bilateral cleft lip and cleft palate patients who had had lip repair only, and generally earlier, the arch contour approached the normal much more closely than a similar group who had both lip and palatal surgery.

Editorials

Institutional and Agency Policies and Practices Related to Medical Care

It should be called to the attention of the medical profession that at the recent meeting of the South Carolina Medical Association the House of Delegates voted to establish a standing committee for the review of economic and professional practices and policies of hospitals and state institutions and agencies whose work deals with the practice of medicine, with regard to their being in the best interest of medical care. Institutions dealing with the practice of medicine are subject to pressures, financial and sociological, from so many sources that practices, potentially harmful to the best interest of the public, may start insidiously and innocently and become well entrenched unless channels of communication are established in order that they can be recognized early and dealt with in their incipiency. The average worker in the institution would not be commonly aware of them as he is engrossed in his personal and departmental problems. In some instances a practice may be advantageous to a particular institution and yet be unsound from the standpoint of public welfare as a result of its adverse effect upon other institutions.

When hospitals were dependent solely upon income from patients, charity, and local taxes for indigent cases, their economy was predominantly that of relating income to the cost of patient care. This relatively simple picture has been changed by the advent of Blue Cross, the tremendous increase of voluntary health insurance and in some cases by State and Federal agencies and various independent health funds. Hospitals in general have increased their facilities, and those receiving income from agencies and voluntary health funds have expanded their activities in the areas of education, training and research —all of which is most commendable. However, the practice of some hospitals to use funds intended for education and research to permit them to accept patients at a per diem below a realistic figure places at a disadvantage, at all economic levels of patient care, those hospitals which do not have access to these funds. Particularly is this the case in contracting for agency and welfare patients, which they desire in order to give them a broad base of operation and for the maintenance of a satisfactory intern and residency training program, in order that they may render a more complete service to the community.

There may be some justification for this practice in connection with obtaining adequate patient teaching material, particularly in the case of county indigent patients where it is aimed at relieving the local tax payers of that element of cost which should be charged to education. On the other hand, the use of this practice should be restricted to the extent that it does not affect adversely the scope and standard of medical services generally available to the public through the hospitals in the vicinity.

Basic hospital economy is directly related to the cost of patient care. This varies with the type of hospital, its facilities and size. Other than by efficient management, the hospital has very little control over this basic factor. Economically, hospitals can be divided into groups depending upon their size, nature of work, and facilities made available. Unless this is taken into consideration by agencies and welfare departments, hospitals which are dependent primarily upon fees from patients are unable to contract with them for their patients for less than the per diem cost, without penalizing private patients to make up the deficit.

An instance of this nature arose recently when a community hospital, which for years had cared for a number of Vocational Rehabilitation cases, was unable to renegotiate a contract, because of the offered less-than-cost basis, with the result that these patients

were sent to a hospital which did not have to adhere to a cost basis or to a hospital outside of the community. It is a well recognized principle in medical care that it is preferable for patients to be hospitalized near their home unless it is necessary to send them elsewhere for special skills and facilities.

A more important instance is that the same hospital was unable to accept Kerr-Mills patients upon the offered less-than-cost basis at a time when the medical profession was making a strong appeal for public support of its position in opposition to socialized medicine. Much capital was made out of this by proponents of the King-Anderson Bill. These two problems have been resolved but only with great effort and after the passage of considerable time during which much damage was done to the cause of sound medical care.

There is the problem of the proper allocation of professional fees paid by patients having been cared for as indigents, when settlement of their case subsequently provides for hospital expenses and also a professional fee. Has the attending physician any claim? If not, how can the fee be used?

In some hospitals low contract Blue Cross-Shield patients are relegated to the status of service cases and thus deprived of choice of physician. A related problem now in the developmental stage, is the practice of some hospitals to use Blue Shield allowances and professional fees from health insurance for the payment of house staff salaries. Recently, the House of Delegates of the American Medical Association has gone on record as disapproving this practice. These practices are directly opposed to the concept upon which the Blue Services were founded, which is that of preserving a private patient-physician relationship, particularly in the low income groups.

By the establishment of this standing committee it is hoped that practices and policies not in the best interest of medical care can be recognized early, and resolved satisfactorily by calling them to the attention of the institution or agency concerned. Problems not thus resolved could be referred to the House of Delegates of the South Carolina Medical Association for consideration and possible professional censure.

William H. Prioleau, M. D.

Cigarettes, Lung Cancer, and the Professional Education Committee

The active Professional Education Committee of the Association is sending letters to all presidents of our county medical societies emphasizing the seriousness of the problem of cancer of the lung. The letters recount the current opinions that cigarette smoking is intimately related to the development of lung cancer and also to diseases of the coronary arteries. The letters ask that the county medical societies emphasize the importance of having youth groups know more about smoking and its relation to cancer.

An illuminating report is made in the letter that in two large city schools, one in Columbia and one in Spartanburg, the large majority of the students smoked one to two packages of cigarettes a day and a few smoked as many as three or four packages.

Statements from local physicians usually carry more weight in their communities than do reports of committees or general news releases. It therefore becomes an important function of the members of the county medical societies to cooperate with the Professional Education Committee and to do all they can to obtain proper publicity in their own areas.

Eat Those Words

Some apprehension was created recently when the magazine, "Escapade," published an article which claimed that the ink used in the printing of one of its issues had been mixed with "a powerful hallucinogen" known as diphenylphloroamyl-2-benzoate. So far, no one has been able to determine that such a compound exists.

Instructions were given that two pages of the magazine be dissolved in methyl alcohol (!!!) and drunk to obtain extraordinary, though not specified, results.

Whether the whole thing was a hoax remains something of a question, but there

were undoubtedly some incredible and credulous readers who might have followed the directions for the use of methyl alcohol, long recognized as a dangerous poison. Various organizations and health bodies interested in the prevention of poisoning of all sorts have seized on this strange situation and have made every effort to spread the word that very serious results might follow the use of the directions given. So far, we've heard of no authenticated cases of poisoning.

The Veterans Hospitals

With a large Veterans Hospital rising under our noses in Charleston, it is interesting to know that the AMA has reiterated its opposition to military veterans getting free hospital services for non-service-connected disabilities and illnesses. Legislation recently proposed would expand greatly free government hospital services to veterans with non-service-connected medical conditions. At the present time the ailments treated in veterans hospitals are only about ten percent service connected.

The AMA still upholds the belief that the best possible medical care should be provided for veterans who need treatment for conditions incurred in military service, but it cannot accept the proposal that any veteran, regardless of the nature of his illness or the condition of his pocketbook should be entitled to free government-provided service. The range of federal responsibility is already stretched and extended to an illogical degree.

Association Receives Plaque

At a luncheon given by the Automotive Crash Injury Research project of Cornell University, the State Board of Health, State Highway Department, and several other organizations which cooperated in the program were represented. Dr. O. B. Mayer, who was President of the SCMA when it started and was instrumental in getting the program off the ground was present.

Final tabulation of the data gathered is not complete so no final report was rendered. The meeting was more to say thanks to the agencies participating.

Plaques were presented to the South Carolina Medical Association, the State Board of Health, the Highway Department and the S. C. Hospital Association. Dr. Frank Owens, President, accepted a plaque for the South Carolina Medical Association, worded as follows:

Certificate of Appreciation
from
Automotive Crash Injury Research
Cornell Aeronautical Laboratory, Inc.
of Cornell University
to
South Carolina Medical Association

In recognition of its participation in the ACIR program conducted in the state of South Carolina, June 1, 1961 through May 31, 1964 as part of the continuing effort to reduce traffic injuries and deaths through automotive safety design.

Robert A. Wolf, Director
Automotive Crash Injury Research
May 26, 1964

New Members, SCMA

Dr. William R. Ameen Greenwood	Dr. Forrest K. Huntington Greenville
Dr. James C. Brice, Jr. Easley	Dr. C. H. Magruder Greenwood
Dr. Sydney E. Carter Newberry	Dr. Douglas C. Owens Greer
Dr. James N. Craigie Loris	Dr. Harris P. Pearson Lake View
Dr. John S. Evans Greenville	Dr. J. F. Richardson Simpsonville
Dr. James A. Gannon, Jr. Aiken	Dr. S. N. Richardson Charleston
Dr. Julian E. Grant Newberry	Dr. Dexter B. Rogers Easley
Dr. Donald P. Harris Summerville	Dr. William R. P. Wilson Seneca

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Special Liaison Committee with S. C. Medical Ass'n. & Dept. Public Welfare

(This Report was not published before the Annual Meeting)

The liaison Committee of the South Carolina Medical Association met with officials of the State Department of Public Welfare on Wednesday, March 18, 1964, at 11 AM in the conference room of the State Department of Public Welfare, Wade Hampton Office Building, Columbia.

Those present were:

Medical Committee

Dr. Wescoat A. Black, Chairman, Dr. Richard M. Christian, Dr. Pierre F. LaBorde.

State Department of Public Welfare

Dr. Arthur B. Rivers, State Director, Mr. F. A. Dean, Chief, Public Assistance, Mr. J. M. Cherry, Chief, Division for the Blind, Miss Alice L. Clark, Supervisor, Medical Care.

Doctor Rivers presented the report of Medical Care for Public Assistance recipients and the Medical Assistance for the Aging for the fiscal year 1963. Copy of report attached. He asked for help and advice of the medical profession in administration of the Medical Care Program.

A revision of policies and procedures on Medical Care was released in January. Copies of the chapter were distributed to the medical committee.

Mr. Dean discussed the medical care program which continues to provide forty days hospitalization for recipients of Public Assistance and Medical Assistance to the Aged. The Medical Assistance to the Aged program is the only group for which outpatient service is provided. The agency has continued the same income limits in the MAA program of $1300 for a single individual and $2100 for a man and wife.

Mr. Cherry discussed the medical programs of the Division for the Blind: Prevention of Blindness and Vocational Rehabilitation. The prevention program is a State financed program and provides for payment of hospitalization and physician's fees. If a Public Assistance case has an injury to his eye or has an acute illness due to an eye condition, hospitalization is paid through the Medical Care fund in order to take advantage of Federal participation.

The Vocational Rehabilitation Program for the Visually Handicapped provides for corrective measures or treatment of any condition which would enable the patient to return to employment or be trained for employment.

Miss Clark reported some changes in the Medical Care program. County departments now are permitted to authorize 20 days hospitalization initially. (Forty days in a fiscal year continues to be the maximum.) This eliminates the majority of extensions and reduces to some degree the paper work involved. The present agreement with the State Board of Cancer Control program enables the State Department of Public welfare to pay for hospitalization for suspected malignancies in any hospital. If malignant, the physician refers to the cancer clinic. The clinics notify the county welfare departments of the acceptance or rejection of the patient for that program. When the condition becomes terminal the clinics notify the county welfare departments and we are again responsible for hospitalization.

Some problems which the agency has are: Use of patients entire 40 days hospitalization on one admission. This may be needed in a few cases but we have a good many instances of this. This penalizes the patient if he does not really need hospitalization for this period of time for he may be acutely ill again and will need additional days. This is a medical decision and the physician has to discharge the patient.

There is a problem in the Medical Assistance to the Aging Program of nursing home care. We can presently provide nursing home care for convalescence following discharge from the hospital. In most of the cases the physician indicates the condition is chronic and we have no program of nursing home care for chronic illness for the MAA patient. In order for him to have nursing home care, his case must be transferred to the Old Age Assistance.

Doctor Rivers commented that a Home Nursing Care program has not been possible since there is no organized service available. The provision for out-patient care for the Medical Assistance to the Aged program has not been extensively used. Wider use of this service could eliminate some of the need for hospital care.

Doctor Rivers gave present plan for payment of hospital costs. Presently we have three ceilings:

1 thru 49 beds	$24.40 Maximum
50 thru 150 beds	25.60 Maximum
150 and over	27.75 Maximum

In arriving at these ceilings the group average is

obtained and 15% added. Most hospitals receive the full per diem cost.

Brochures on Medical Assistance to the Aging were distributed last year by the Department of Public Welfare and this year by the Medical Association, Blue Cross and the Department.

Dr. Rivers expressed appreciation to the Medical Association for their cooperation in administering the Medical Care Program.

Respectfully submitted,
Alice L. Clark, Recorder

3-20-64

SOUTH CAROLINA MEDICAL CARE PROGRAM

EXPENDITURES FOR THE FISCAL YEAR JULY 1, 1962 THROUGH JUNE 30, 1963

Type of Care and Program	*Number of Patients*	*Number of Days Care*	*Amount*
In-Patient Hospitalization			
Public Assistance	11,036	115,913	$2,326,483.26
Medical Assistance for Aged	5,670	66,578	1,371,709.04
Total In-Patient Hospitalization	16,706	182,491	$3,698,192.30
Convalescent Nursing Care			
Public Assistance	830	21,514	$ 103,262.59
Medical Assistance for Aged	489	12,580	50,158.33
Total Convalescent Nursing Care	1,319	34,094	$ 153,420.92
MAA—Out-Patient Service	3,407		$ 28,608.50
Total	21,432	216,585	$3,880,221.72
Chronic Illness Nursing Care from February through June, 1963	1,163		$ 564,526.18
Total All Programs	22,595	216,585	$4,444,747.90

In-Patient Hospitalization Averages

Per Patient	$221.37
Per Day	$ 20.26
Average Stay	10.9 Days

Refunds from Hospitalization Insurance Benefits $ 85,382.25

Excerpts from S. 855

In the House of Representatives

An Act

To provide for more effective utilization of certain Federal loans or grants by encouraging better coordinated local review of State and local applications for such loans or grants.

---

and to encourage State and local governments to establish or improve facilities for coordinating areawide development.

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each application for a loan or grant of the type described in section 1 shall be accompanied (i) by the comments and recommendations with respect to the project involved by a planning agency designated to perform metropolitan or regional planning for the area within which the assistance is to be used.

The comments and recommendations and the statement referred to in this section shall, except in the case referred to in subsection (b) of this section, be reviewed by the agency of the Federal Government to which such application is submitted for the sole purpose of assisting it in determining whether the application is in accordance with the provisions of Federal law which govern the making of the loans or grants.

(a) "Comprehensive planning" includes the following, to the extent directly related to area needs; (1) preparation, as a guide for long-range development, of general physical plans with respect to the pattern and intensity of land use and the provision of public facilities, including transportation facilities, together with long-range fiscal plans for such development; (2) programming of capital improvement based on a determination of relative priority together with definitive financing plans for the improvements to be constucted in the earlier years of the program; (3) coordination of all related plans of the departments or subdivisions of the government concerned; (4) intergovernmental coordination of all related planned activities among the State and local governmental agencies concerned; and (5) preparation of regulatory and administrative measures in support of the foregoing.

(d) "Planning agency" means an official State, or metropolitan, or regional planning agency empowered under State or local laws or under an interstate compact or agreement to perform planning in an area, or such other agency or instrumentality as may be designated by the Governor.

LABELING PRESCRIPTIONS WITH NAMES OF INGREDIENTS

J. Hampton Hoch

Prescriptions used to be written in Latin and very few patients could decipher them or recognize what medication they were receiving. Physicians, in general, looked with disfavor on any pharmacist who answered queries about the identity of the medicament or its probable activity.

Today's generation of patients is better educated in health matters (including materia medica) but probably less capable of deciphering Latin; however they can read English, especially if typewritten on the label and they do recognize well-publicized trade names of drugs. Even chemical jargon, perhaps shortened into a generic name, has a vague meaning for some patients. Familiarity often leads to contempt and although recognition of a drug name is hardly familiarity with it, a degree of casualness toward dangerous drugs may result from the patient's repeated exposure to promiscuous "name calling."

Last July an editorial in the *JAMA* announced that the Council on Drugs favored the labeling of prescription drugs "as a general rule."
The reasons were that:

1. Information will thus be readily available if the patient develops symptoms which may be untoward reactions to the drug or may result from too high a dose.

2. Information will be invaluable if the patient changes doctors, moves to another locality or contacts the doctor when his records are not at hand.

3. In cases of attempted suicide, accidental overdosage, or accidental poisoning of children the name and strength of the drug on the label may save precious minutes and could be lifesaving.

4. Naming the drug or at least indicating its purpose on the label helps to avoid mixups between several prescriptions which are being taken concurrently, or between drugs used by different members of the family.

The editorial acknowledged that there must be some exceptions. For example, opiates and barbiturates should sometimes remain nameless. Also some patients were better off not knowing what they were taking. Going on to say that "labeling prescriptions is one more step toward bringing about better understanding between patient and physician," and to recommend that prescription blanks contain boxes for checking "yes" or "no", and that if the physician fails to indicate a choice "the prescription will be labeled" seem to be conclusions which were less carefully thought out.

Three parties can potentially benefit from the ready availability of information as outlined above, the patient, the prescriber, other physicians. Let us consider them in that order.

The patient: who develops symptoms and reactions from drug dosage can more quickly be advised by his doctor or another physician when the name of the drug can instantly be given to guide the advice; when he changes doctors, the new physician instantly knows what drug has been effective (or ineffective); if he moves to another locale and presumably another physician takes charge, the situation is like that above; if overdosage occurs (accidental, suicidal, or a child's ingestion), the time saved in identifying the drug might be very crucial.

The prescriber: may be called at home, away from his records, about symptoms and apparent drug reaction to his prescription and saves time if he cannot recall what he had ordered; on emergency call to counteract overdosage he need not refer to office records for identity and strength of the drug: may establish a "better understanding" with his patient, although this seems to be a rather tenuous proposition.

Other physicians: who may be called on to treat symptoms and reactions evoked by the drug can act more promptly and surely; who are called to succeed the prescriber in attendance immediately learn the therapeutic history of the case; who may have to treat poisonous overdosages.

The above are plus values that can accrue from records for identity and strength of the drug; However, there are minus points to be made also. The unilateral action by the *AMA* without inter-professional conferences perhaps explains why other public health reasons of a minus value were not set forth. Pharmacy certainly is not opposed to such labeling when it is in the patient's best interest and when good and sufficient reasons exist in particular cases for so doing.

But to establish *routine* labeling of prescription medication even if the physician fails to request it (by checking a box on the blank) could become a compensation for a lack of adequate record keeping by the prescriber. Certainly the physician has the right in each case to decide whether he wants such information on the label. The "negative consent" which is implied in the Council's resolution and now being proposed in some quarters as a blanket labeling requirement needs further consideration.

Consideration must be given to the fact that naming ingredients on prescription labels encourages self-diagnosis or neighbor-friend diagnosis and treatment. Pharmacy has been striving to counteract this all too human failing and has stressed the need for professional consultation of a doctor. Restrictions on prescription renewals, and generally tighter control

of potentially dangerous drugs have resulted from these efforts. It is paradoxical to see physicians trending away from such efforts.

Because drugs are often used for a number of different purposes, an article written for the public about one of a drug's uses while the patient is taking it for another purpose could cause anxiety or even lead the patient to discontinue needed medication.

Our laws already specify what information should be on a prescription label, and they do not include the name of a drug. True, they can be amended to include this information also. But is that what protection of the public health requires?

Suppose a pharmacist were to include the drug's name on a label without specific instructions from the prescriber (based on the Council's resolution) and harm would come to the patient thereby, where would the legal liability rest?

What form should the labeling identification take? Should it be exactly as written by the prescriber (even if misspelled)? Conceivably this form might be (rarely) a Latin name, an official title, a proprietary name, a generic name.

Yes, there are points that need discussion by a joint group of physicians and pharmacists before any ultimate decision on labeling is reached.

News

Fifth National Cancer Conference

Sponsored by the American Cancer Society, Inc. and the National Cancer Institute
Bellevue-Stratford Hotel
Philadelphia, Pennsylvania
September 17, 18, and 19, 1964
For further information write:
Coordinator, Fifth National Cancer Conference
American Cancer Society, Inc.
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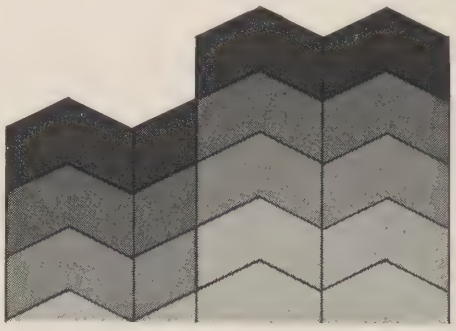
Dr. Thomas Parker

Dr. Thomas Parker of Greenville has been elected to the board of trustees of the Americans for Constitutional Action, an organization whose goal is to preserve the Constitution.

Dr. Parker is head of the Association of American Physicians and Surgeons, Inc. He entered practice in Greenville in 1938, where he has lived since except for a six-year tour of active duty during World War II as a Marine flight surgeon.

of all oral corticosteroids:

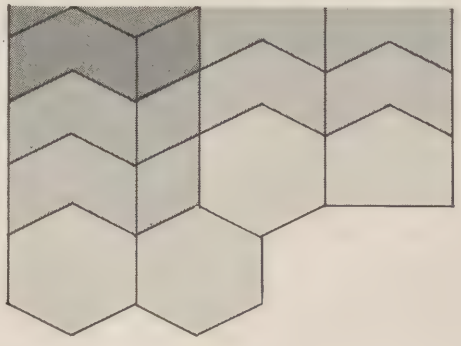




one of the most
powerful antirheumatic
glucocorticoids yet
synthesized[1]

among the highest on the activity spectrum
among the lowest on the cost spectrum

priced substantially
lower than the majority
of analogous compounds



Dr. Gurdon W. Counts

Dr. Gurdon W. Counts has moved to Batesburg-Leesville to begin practice. Dr. Counts graduated in 1955 from Newberry College and in 1959 from the Medical College of South Carolina. Prior to coming to this community he served as a Captain with the United States Air Force, stationed at Andrews Air Force Base in Maryland.

Dr. John Griffin

Dr. John E. Griffin, Radiologist, has located in Marion and is now supplying his services daily to the Marion and Mullins hospitals and to St. Eugene.

Dr. Griffin is a native of Grand Prairie, Texas, born in 1926. He received the degree of B. S. in Pharmacy from the University of Texas in 1948. He had four years experience as a druggist before entering Southwestern Medical School at the University of Texas, where he received his M. D. degree. He interned at Methodist Hospital in Dallas and was a general practitioner for three and a half years before completing his residency in Radiology at Baylor University Medical Center.

Health Mobilization Training Course

The Health Mobilization Training Course scheduled for June 9 and 10, 1964 at the Veterans Administration Hospital Auditorium in Columbia has been postponed. It is hoped that it will be possible to conduct this course during the Fall of 1964.

Diabetes Seminar

The Florida Diabetes Association will conduct its annual Seminar on Diabetes and Related Endocrine Disorders September 30, and October 1 and 2, 1964, at the Balmoral Hotel, Miami Beach, Florida.

The guest speakers will be: Eugene C. Erkins, M. D., Robert Greenblatt, M. D., William Kirkley, M. D., Leo P. Krall, M. D., William Locke, M. D., C. J. O'Donovan, M. D., and Raymond Randall, M. D.

The other speakers will be members of the Faculty of the School of Medicine, University of Miami.

The registration fee is twenty dollars which should be sent to the President of the Association, George F. Schmitt, M. D., 30 S. E. 8th Street, Miami, Florida. Because of space, the number of registrants is limited to 125.

Reservations for hotel rooms (which are $10 single and $12 double daily) may be made directly with the hotel.

The complete program is now being printed, and should be available shortly. If you wish a copy, please send a post-card to the President, and it will be sent as soon as it is ready.

Tennseess Valley Medical Assembly

Tivoli Theater, Chattanooga, Tenn., September 28-29, 1964. Dr. Rudolph M. Landry, Chairman, 109 Medical Arts Bldg., Chattanooga, Tenn.

DEXAMETH (dexamethasone) exerts a prompt and potent ameliorating effect in patients with rheumatoid arthritis[2]; symptoms of inflammatory reaction are quickly suppressed in a substantial proportion of patients, joint stiffness is relieved and function improved.

DEXAMETH (dexamethasone) is less likely than some of the older steroids to produce electrolyte imbalance, hypertension, and disturbance in carbohydrate metabolism. Abnormal weight gain may limit the usefulness of the drug in some patients, but may be advantageous in others.

PRECAUTIONS: At therapeutic dose levels, DEXAMETH (dexamethasone) may have less tendency to cause sodium or water retention, potassium excretion, disturbance in glucose metabolism or hypertension than some of the older steroids. With these exceptions, however, the drug may give rise to the metabolic and hormonal side effects characteristic of corticosteroids. It should, therefore, be used with great caution in the presence of tuberculosis and other infections, osteoporosis, peptic ulcer, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, herpes simplex, psychotic tendency, pregnancy and in persons exposed to chickenpox, measles or scarlet fever.

CONTRAINDICATIONS: Ocular herpes simplex, arthritis complicated by psoriasis, tuberculosis of the eye and skin, fungal keratitis, and local pyogenic infection.

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DEXAMETH®
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TABLETS 0.75 mg. and 0.5 mg.

Dosage: In rheumatoid arthritis, the initial daily dosage ranges from 1.5 to 3.0 mg. The dosage is then decreased gradually to the minimum that will maintain sufficient relief; this may be as little as 0.75 mg. per day. After extended therapy, it is especially important that the drug be withdrawn gradually to allow recovery of normal adrenal function.

1. Ringler, I., West, K., Dulin, W. E. and Boland, E. W.: Metabolism 13:37, 1964.
2. Black, R. L., et al.: Arthritis and Rheumatism 3:112 (April) 1960.

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Dr. Phillip J. Haggerty

Dr. Phillip J. Haggerty, specialist in general surgery, plans to locate in Gaffney in the latter part of July.

Dr. Haggerty of Kalamazoo, Michigan, was born in Media, Illinois. He graduated from the University of Illinois College of Medicine in 1954 and completed a rotating internship at the Illinois Central (Railroad) Hospital in Chicago.

A veteran of four years naval service, Dr. Haggerty served as flight surgeon at Pensacola, Florida; Edenton, N. C.; and Beaufort. He is completing a five year general surgery residency at Kalamazoo, Michigan.

Dr. Haggerty is trained and experienced in thoracic surgery, vascular surgery, plastic surgery, and gynecology.

Mental Health Board

Dr. Charlton deSaussure, Dr. Junius M. Rowe, and Dr. J. J. Cleckley were named to the Charleston County Mental Health Board. The Charleston County Medical Association will be asked to name two more doctors to the board.

Dr. W. F. Ward

W. F. Ward, M. D., opened offices in West Columbia on June 1.

Dr. Ward attended Bob Jones University, University of South Carolina and Medical College of South Carolina.

His internship was served at Columbia Hospital, and his experience included one year on the staff of South Carolina State Hospital.

Dr. Ward has practiced general medicine at 1519 Marion Street in Columbia for the past six months.

S. C. Board of Medical Examiners

Seven physicians have been newly licensed to practice medicine and surgery by the South Carolina Board of Medical Examiners.

They are Dr. John S. Evans, Greenville, a 1958 graduate of Duke; Dr. James S. Fulmer, Spartanburg, a 1957 graduate of Emory; Dr. John E. Griffin, Marion, 1956 graduate of the University of Texas Southwestern Medical School; Dr. Falls L. Harris, Greenville, 1960 graduate of the University of North Carolina.

Also, Dr. John F. Shaul Charleston, 1937 graduate of New York Medical College; Dr. Robert M. Wentz, Lockhart, 1963 graduate of Tulane, and Dr. Kenneth T. Williams, Spartanburg, 1954 graduate of Duke.

Dr. Hicklin Opens Office

Cloud Hardin Hicklin, M. D., began the practice of medicine in Chester about July 1st.

Dr. Hicklin received his A. B. Degree from Presbyterian College, and served in the U. S. Air Force for four years.

He received his M. D. Degree from the Medical College of South Carolina in 1962. He completed his internship at Memorial Hospital of Chatham County in Savannah, Georgia in 1963, and has completed one year of internal medicine residency at the same hospital.

South Carolina Pediatric Society

The Annual Scientific Meeting of the South Carolina Pediatric Society will be held at Adventure Inn, Hilton Head Island on September 11-13, 1964.

Book Reviews



THE MANAGEMENT OF A MEDICAL PRACTICE, by Alan E. Nourse, M. D. and Geoffrey Marks, M. A. J. B. Lippincott Company, Philadelphia, Montreal. $9.00.

This book adequately covers the subject of the title and is an authoritative and welcome addition to the limited literature concerning this important and too neglected aspect of medical practice.

The authors cover in detail all phases of the business aspects of medical practice. One will not find the implementation of all the management procedures immediately applicable to any one situation, however, the consideration of the material presented will be helpful in handling many of the problems which physicians find most vexing.

The summary and conclusions section with its philosophical and practical analysis is excellent and should be read first. All physicians regardless of type of practice will find something of interest and value in this book.

George G. Durst, M. D.

CLINICAL METABOLISM OF BODY WATER AND ELECTROLYTES. By John H. Bland, M. D. 623 pages. W. B. Saunders and Co., Philadelphia, 1963. $16.50.

The new edition of this work represents an enlargement of the previous volume, incorporating in-

in virtually all diarrheas...prompt symptomatic control

LOMOTIL®

TABLETS / LIQUID—Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.



Lomotil controls the basic physiologic dysfunction in diarrhea—excessive propulsive motility. Pharmacologic evidence indicates that it does so by directly inhibiting propulsive movements of the intestines. This direct, well-localized activity controls diarrheas of widely varied origin and does so promptly, conveniently and economically.

The relatively few conditions in which Lomotil has given less than satisfactory control have been, for the most part, those such as severe ulcerative colitis in which too little anatomic or functional capacity of the intestines remains for the motility-lowering action of Lomotil to have effect.

It should be noted, however, that Lomotil has proved highly useful in mild to moderate ulcerative colitis and in several other refractory forms of diarrhea.

The recommended initial adult dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months to 10 mg. for one 8 to 12 years of age. Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Research in the Service of Medicine SEARLE

formation that has evolved since the earlier work. Knowledge in the field of fluid and electrolytes is rapidly accumulating. Such growth justifies the present edition's selection of 21 contributors who are well qualified in the field to present all aspects of an area of medical discipline grown too large for one individual to encompass.

The book continues to be a standard for the clinical study of fluids and electrolytes. Its consideration of the problem is of sufficient scope and depth to interest even the most serious and mature student of fluid balance. The illustrations are satisfactory even if one might wish for more. The text is probably as clearly written as is possible with the subject.

This work is highly recommended for all medical levels, from the clinical novice beginning his study to the practitioner needing a reference for daily problems in fluids and electrolytes.

Louie B. Jenkins, M. D.

PREVENTIVE MEDICINE IN WORLD WAR II, VOLUME VI, COMMUNICABLE DISEASE, MALARIA. Office of the Surgeon General, Department of the Army, Washington, D. C., 1963. $6.25.

This volume, which concerns itself entirely with the problem of malaria, is one of a series reviewing the history of the Medical Department of the United States Army during World War II. Each section, written by different authors with first-hand experience, deals with the preventive aspects of malaria in varying geographic areas in which American troops were stationed. Much valuable organizational, topographic, climatologic and entomologic data peculiar to many parts of the world is included in the many tables and charts. In a presentation of this type, there is necessarily much overlapping, and this publication is not designed for cover-to-cover reading. At times the description is heavily weighted toward organizational and administrative details. Still, the failures, the triumphs and the ultimate control of malaria under varying conditions are depicted in interesting fashion. This book should prove to be a helpful reference to all interested in the history of man's conquest of infectious disease. Of more importance is the prospective value of this volume as a reference for those engaged in the global control of infectious diseases now and in the future, especially under combat conditions. Those who encouraged this publication and participated in this enormous undertaking are to be commended for a valuable contribution.

—Louis P. Jervey, M. D.

ATLAS OF BONE TUMORS, INCLUDING TUMORLIKE LESIONS. By W. S. Gilmer, Jr., G. B. Higley, Jr., and W. E. Kilgore. The C. V. Mosby Co., St. Louis, Mo. 1963. 163 pages, with 311 figures, 190 of which are in color. $27.50.

This entirely new book documents the pathological material of the Campbell Clinic and the University of Tennessee. The text actually represents a compendium, and since it presents only the material of these two clinics, the less frequently seen conditions are omitted.

Since the book is characterized as an atlas, it is principally concerned with presenting pictorially the various lesions grossly and microscopically. The many illustrations in color add a great deal to the clarity of presentation. The illustrations of the gross lesions are good, but many of the photomicrographs are insufficiently clear for critical study of the lesion represented. The text is sufficient to give a concise review of the salient features of the conditions presented.

An appendix enumerates the numbers of cases represented in the different categories of the 220 consecutive destructive lesions of bone studied, giving a clear idea of the relative frequency of each condition. An excellent bibliography is appended, and an original and interesting classification of bone tumors is included, based on histogenesis.

The book does not pretend to be complete, and its chief usefulness will be for rapid review of bone tumors and tumorlike lesions by residents, or for an introduction to the subject for students.

John A. Siegling, M. D.

FITNESS FOR THE WHOLE FAMILY, Edited by Paul Dudley White and Curtis Mitchell, Doubleday & Company, Inc., New York. 1964. Pp. 302. $4.95.

Man's accomplishment in developing ways and means of sparing his physical energy and activity has rebounded to his physical detriment. However much the physical body may be spared by our modern devices, it has not adjusted itself to the point that it does not require much of the old activity that kept it in repair.

Frequent complaint has been heard over the years that we are a physically unfit race, and the recent emphasis on the importance of exercise for all by the American Medical Association and the American Association for Health, Physical Education and Recreation points up the value and the near necessity of physical activity as a means of avoiding disease or improving diseased conditions.

This book by nineteen contributors, prefaced by Dr. Paul Dudley White, expresses the concern of many authoritative people for the lack of consistent exercise in the population and offers practical advice as to how the use of exercise may be encouraged and effected. It includes a considerable section of detailed illustrated directions for exercises of various sorts. It is undoubtedly authoritative and potentially stimulating. It would seem to negate the story of the old fellow who, when asked what exercise he took, replied only that required for acting as pallbearer to his athletic friends.

JIW

MEDICAL DEPARTMENT, UNITED STATES ARMY—ORGANIZATION AND ADMINISTRATION IN WORLD WAR II. Editor in Chief, Colonel John Boyd Coates, Jr., MC, USA. For sale by Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. 1963. $6.25.

This book is important from a medico-military standpoint because it outlines the administrative structure of the Army Medical Department in World War II.

It would be invaluable as a guide for those who would be concerned with the expansion of medico-military services from a peace to a war footing in the event of another world war.

One of the greatest lessons learned in World War II was that at every level of command, the surgeon, if he is to carry out his mission effectively, must be an active and distinct member of the commander's staff, and must have direct access to the commander at all times.

Another lesson soon learned was that many of the pre-war concepts regarding field hospitalization and evacuation had to be changed on the spot to meet the varied local situations found overseas. Fortunately, air evacuation quickly came into its own, and was used very effectively in keeping up with the fast moving military situations in the various overseas theaters.

The authors gave due credit to the command surgeons of all echelons for their part in developing a global organization which reduced the morbidity and mortality rates of their war casualties to an unprecedented low.

O. S. Reeder, M. D.

CURRENT DIAGNOSIS AND TREATMENT by Henry Brainerd, Sheldon Margen and Milton J. Chatton. First Edition. Lange Medical Publications, Los Altos, California. Pp. 870. $9.50.

This text gives an excellent quick reference manual of the generally accepted therapy of a wide variety of ills. There are several advantages of this over other similar references, the first being the presence of a bibliography after each subject discussed. Secondly, the disease is discussed briefly regarding its etiology, symptoms and natural course as well as the treatment most commonly recommended.

The pharmacology of various therapeutic agents (i.e. quinidine, penicillin, etc.) are discussed separately and this review of the indications, contra-indications and pitfalls of different drugs is extremely useful for the physician who might use a particular agent infrequently. A further review of normal figures for laboratory values and the interpretations of any deviation from the normal is also an excellent source of information.

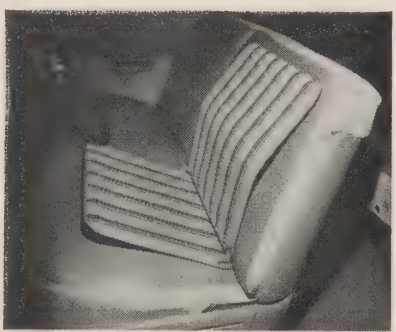
This text has in it a rather amazing amount of information, is well organized, and can be recommended as a very useful addition to the medical library of any house staff physician or practitioner.

Charlton de Saussure, M. D.

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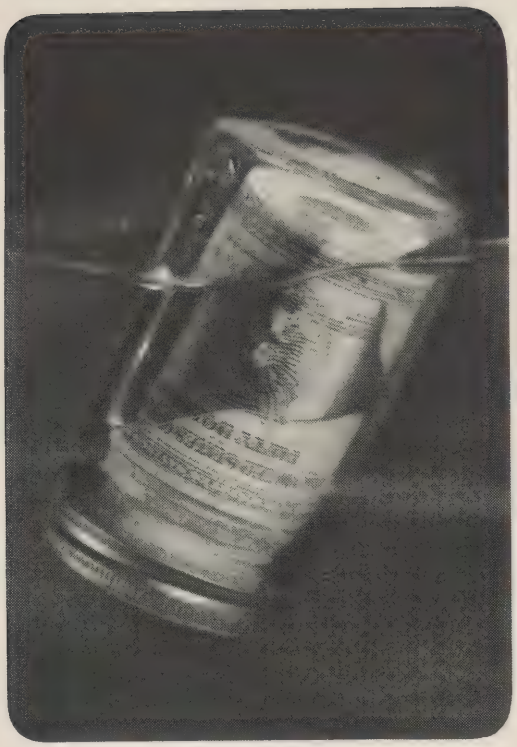


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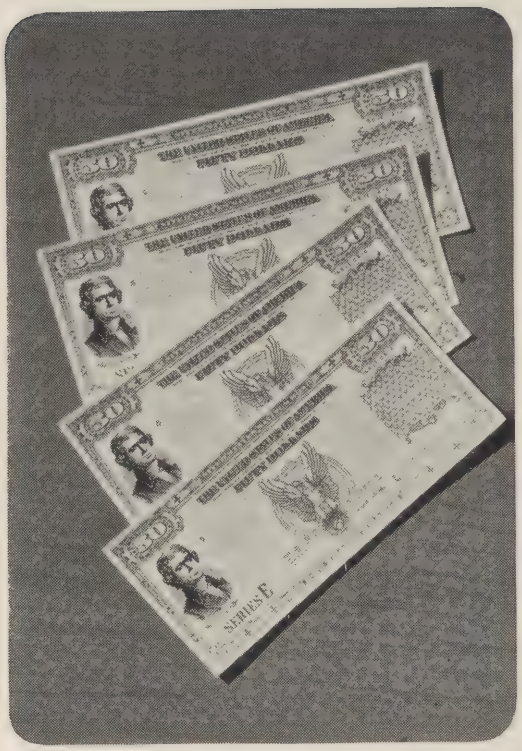


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It all started when Mr. Adams buried a glass jar containing $1625 in Savings Bonds under his home. A heavy rainstorm, an unusual amount of seepage, and a leak in the jar produced a gummy wad that bore little resemblance to the former family savings.

Fortunately, the Chicago office of the Treasury Department could check the record of Mr. Adams' purchase, and issue new Bonds—no charge. (Mr. Adams sent them the serial numbers, but the Treasury could have traced the Bonds even if he hadn't.)



Bailed out in Chicago

Every Bond purchase is recorded on film so it can be quickly traced, and the Bond replaced if lost or destroyed. This helps make Savings Bonds one of the safest places in the world to put your money. Uncle Sam guarantees it.

And incidentally, the more Bond dollars you lend Uncle Sam, the stronger our country will be. And the straighter Uncle Sam can stand up for freedom. Aren't those both pretty good reasons for you to buy Bonds?

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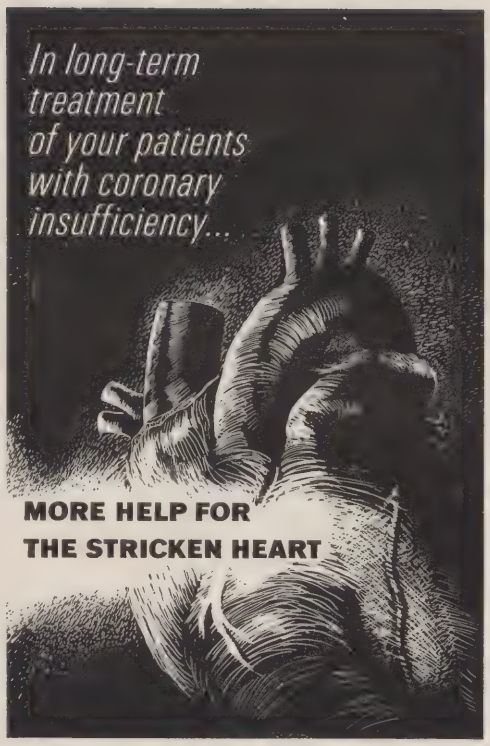
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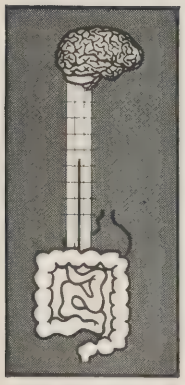
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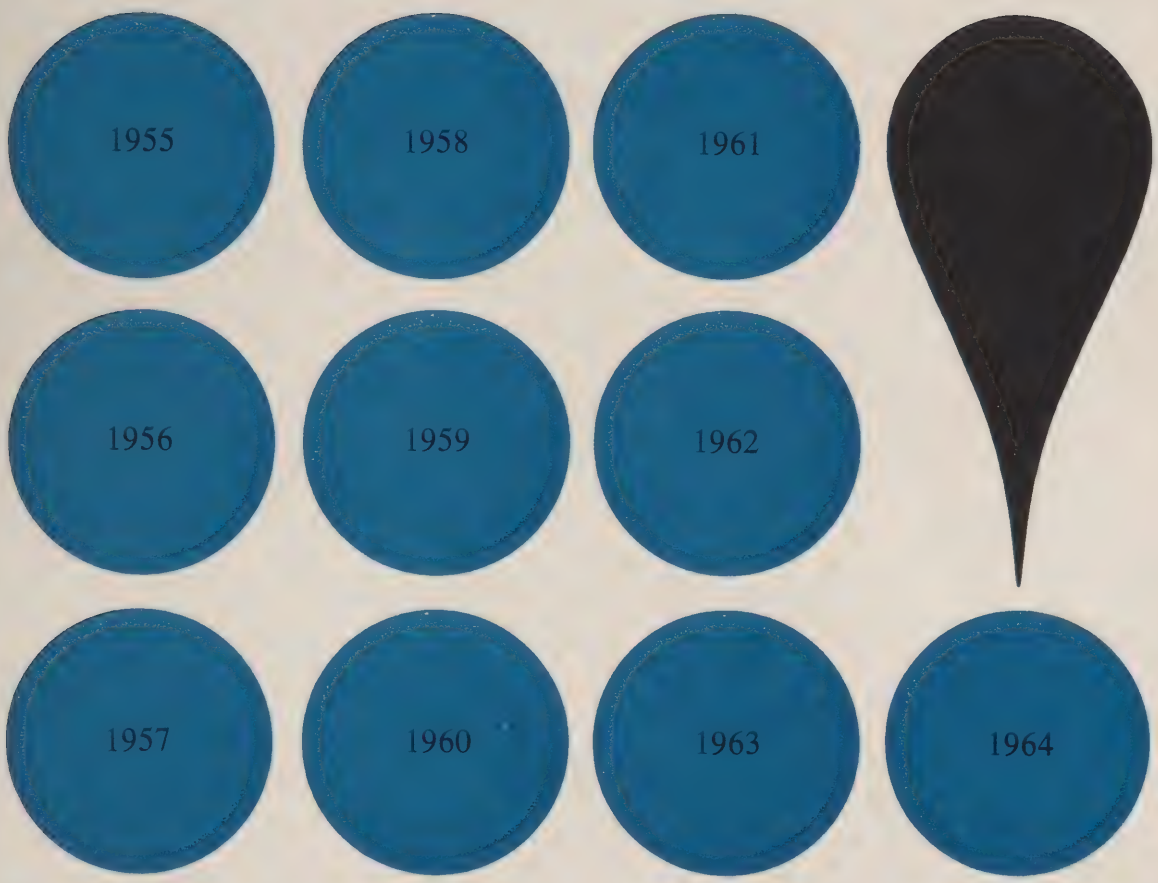
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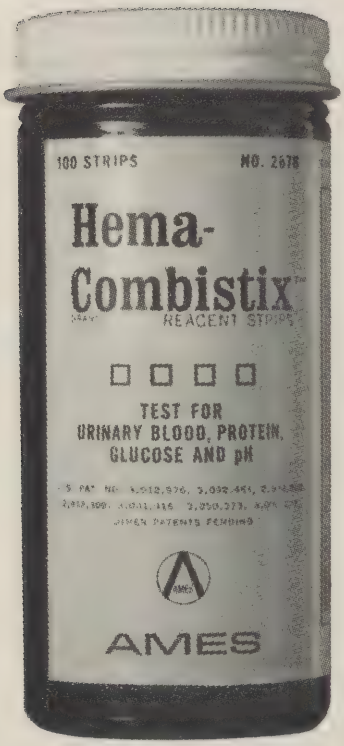


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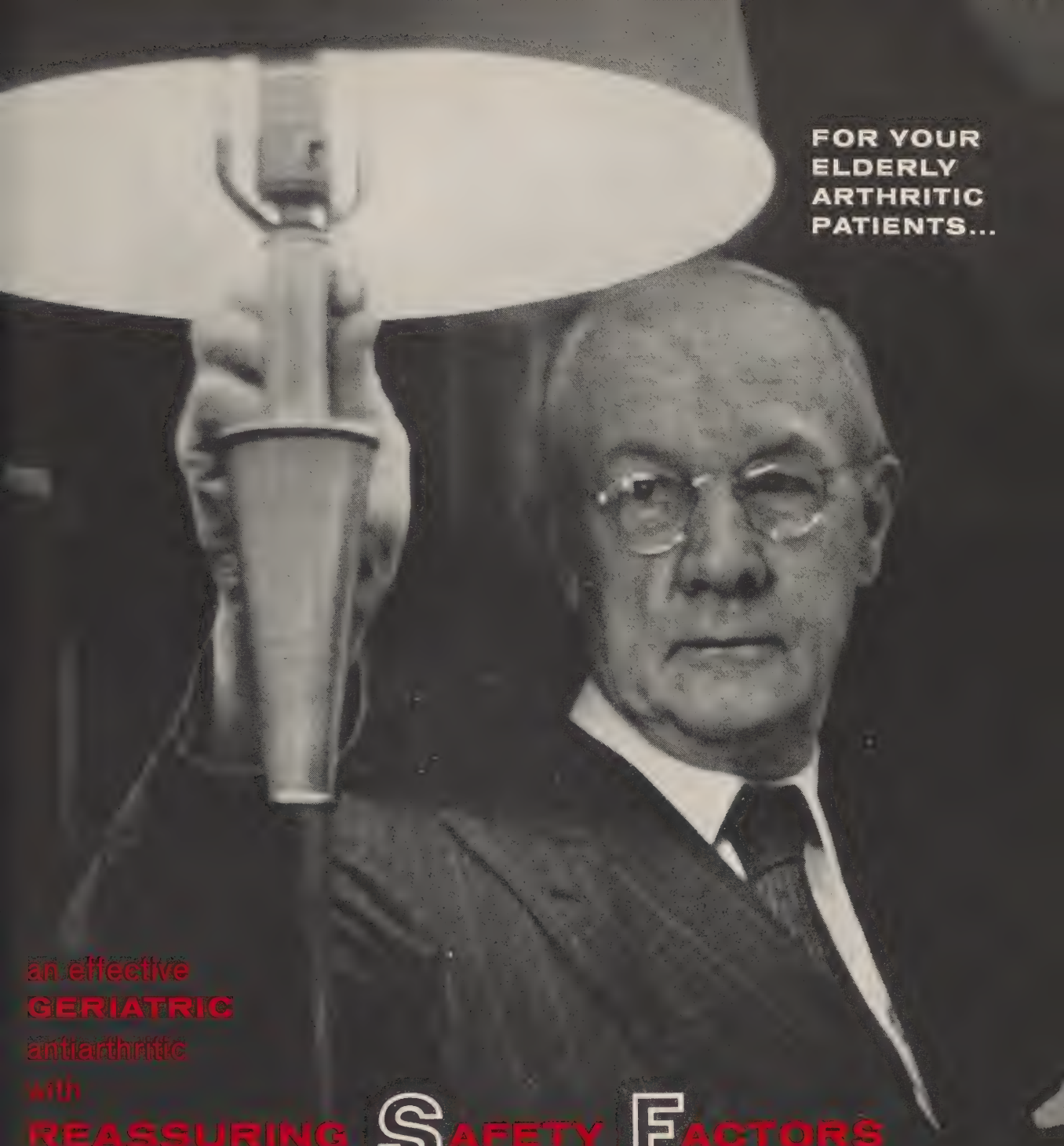
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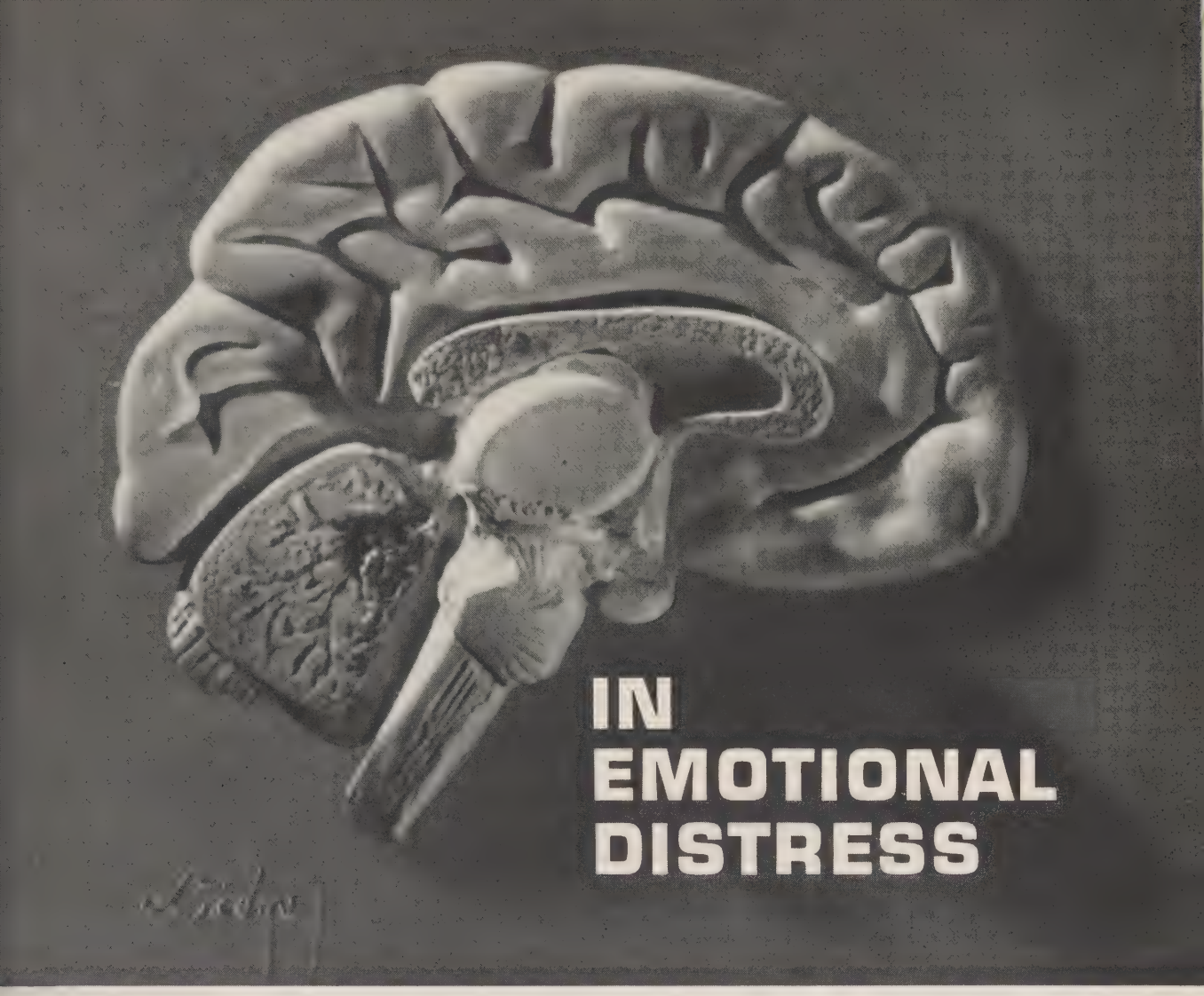
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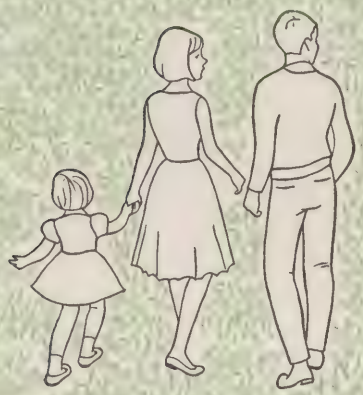
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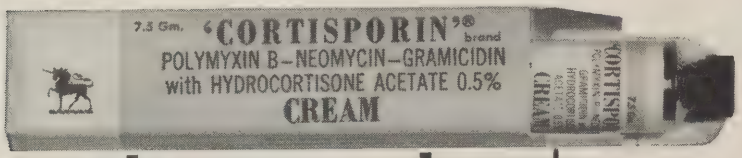
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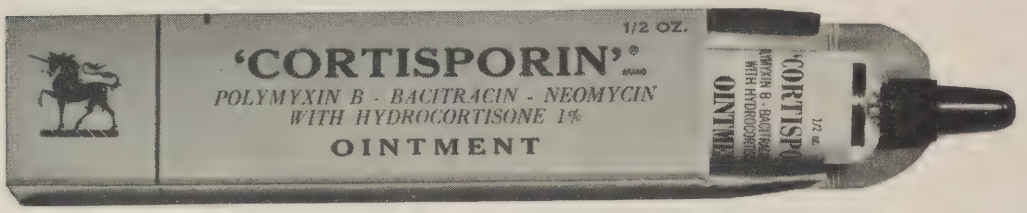
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In a special white petrolatum base.

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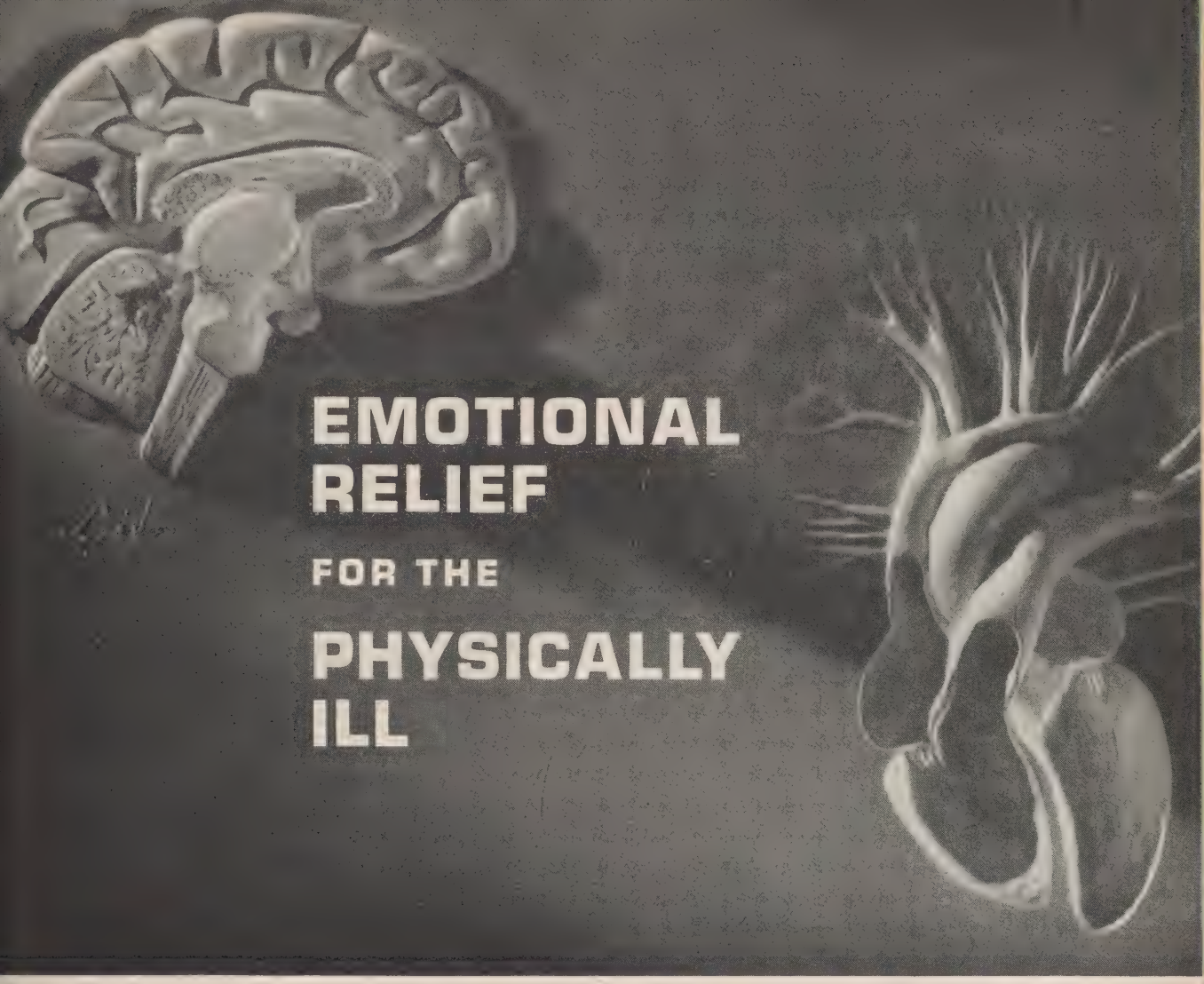
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Contraindications: These drugs are contraindicated in tuberculous, fungal or viral lesions (herpes simplex, vaccinia and varicella).

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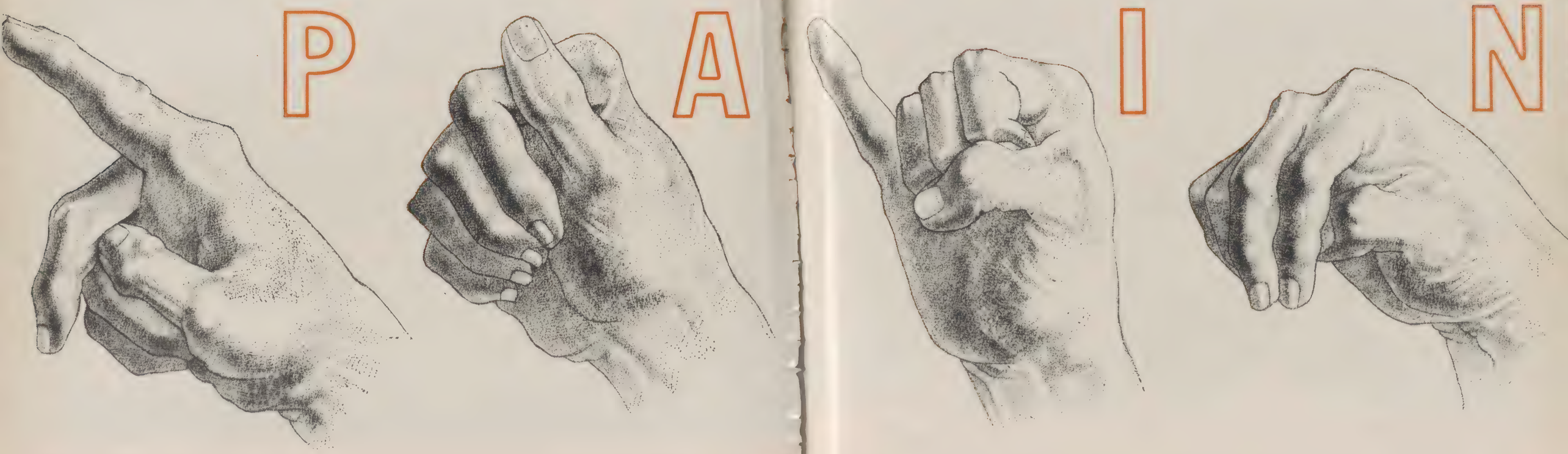
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PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

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*Cohen, et al: J.A.M.A., 165:225, 1957.

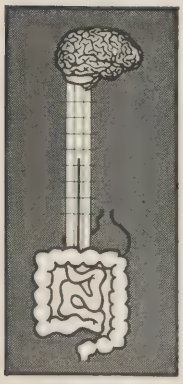
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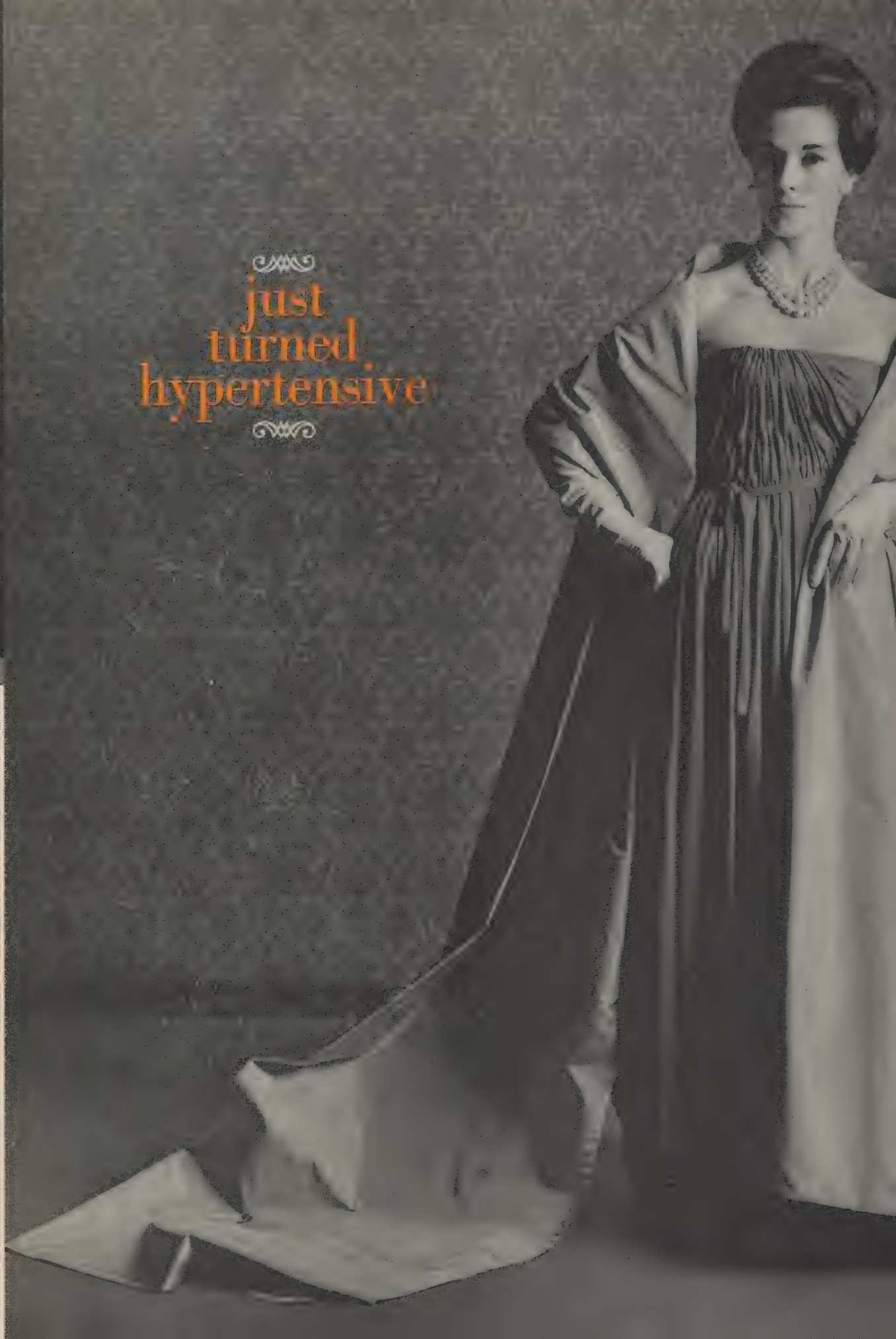
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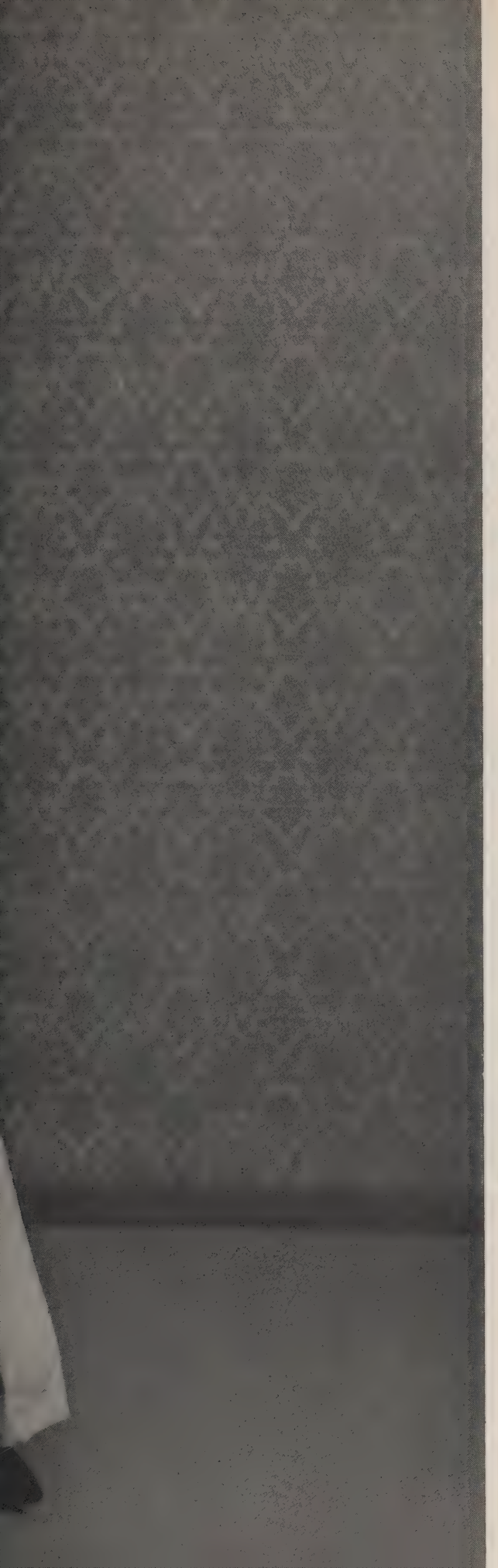
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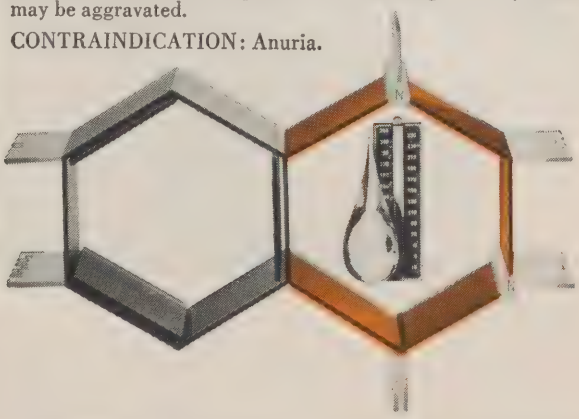
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CONTRAINDICATION: Anuria.



1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. *J. Amer. Geriat. Soc.* 11:945 (Oct.) 1963.
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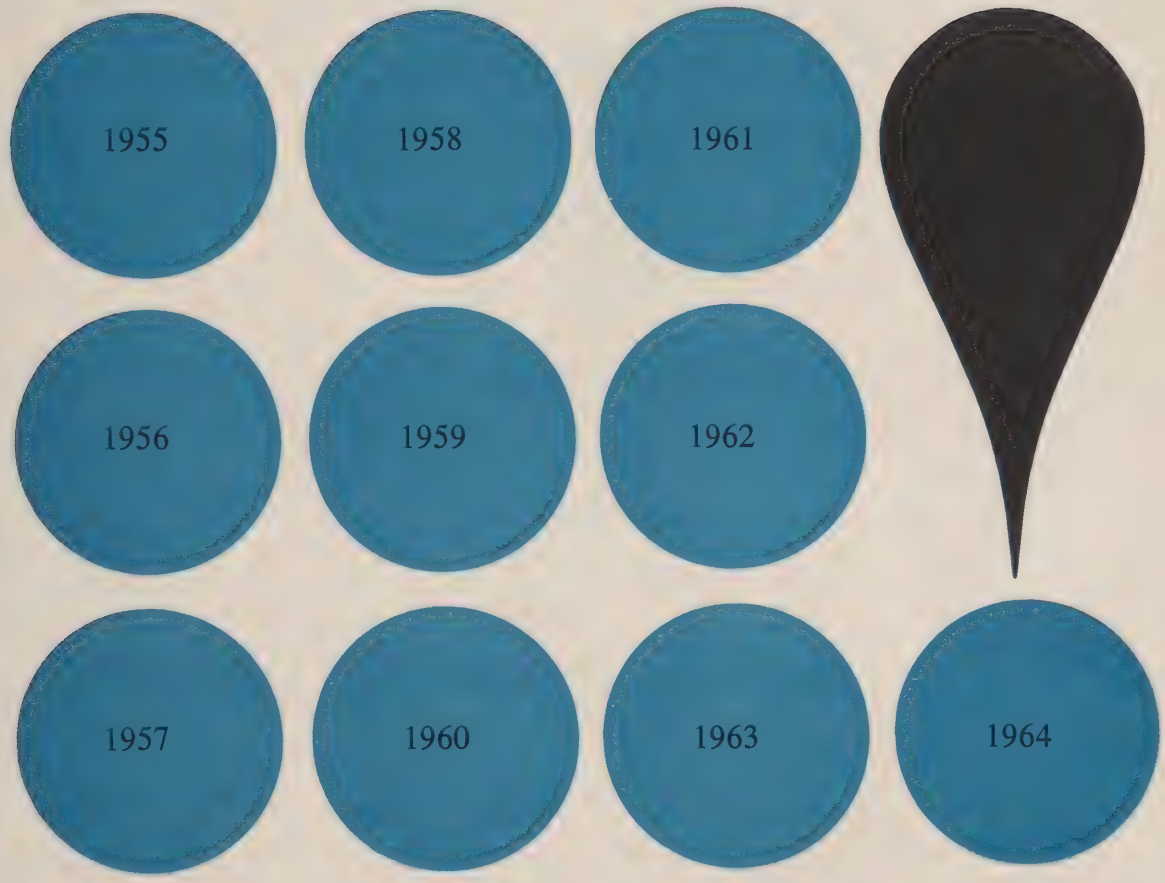
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The Journal
of the
South Carolina Medical Association

VOLUME 60 August, 1964 NUMBER 8

EXCRETORY UROGRAPHY BY-PRODUCT OF CEREBRAL ANGIOGRAPHY

EBEN ALEXANDER, JR., M. D.
OLIVER CHARLES MITCHELL, M. D.
KENNETH G. S. FERGUSON, M. D.
LAURENCE B. LEINBACH, M. D.
Winston-Salem, N. C.

The radiopaque dyes used in cerebral angiography are also those commonly utilized for excretory urography. Patients prepared for cerebral angiography are moderately dehydrated so that excretion through the urinary tract is adequate. Special bowel preparation, a routine part of the preparation of the patient for intravenous urography, is not undertaken.

The policy has been followed here and elsewhere[1] for several years of taking a film of the abdomen (KUB) after cerebral angiographic studies in the hope of demonstrating changes in the urinary system which might influence the treatment of the primary neurologic disorder.

Excretory urography originally was developed as a by-product of the study of the treatment of syphilis. Paul Ehrlich, professor of chemistry at the University of Berlin, developed salvarsan. He was succeeded by Arthur Binz who fell heir to Ehrlich's notebooks; he continued to study salvarsan, attempting to find a better antisyphilitic drug. Because his further studies with the benzol ring series failed to produce a more satisfactory remedy, he studied the pyridine ring preparations. Instead of originating a new antisyphilitic drug, he accidentally became the father of both excretory urography and cerebral angiography through the discovery of selectan (Iopax).

The excretory urogram was introduced first in 1929, and it remains one of the most valuable single roentgenologic examinations employed in clinical medicine. It is entirely a physiologic determination, commonly performed to learn the functional status of the kidney (Fig. 1), but the usefulness of this test is not restricted to the needs of the urologists.

Bigelow,[2] and subsequently Spring and Gross,[3] indicated that there is an increased incidence of polycystic kidneys in patients with congenital intracranial berry aneurysms. Bigelow compiled from the literature 360 cases of such aneurysms, of which 21 (5.9

Presented at the meeting of the American Academy of Neurological Surgery, Palm Springs, California, October 24, 1963.

From the Department of Surgery, Section on Neurosurgery, and the Department of Radiology, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, North Carolina.



Figure 1
Post-angiographic KUB film demonstrating obstruction of right ureter, probably by calculus.



Figure 2
Post-angiographic KUB film showing polycystic kidneys.



Figure 3
Post-angiographic KUB film revealing primary tumor in upper pole of right kidney.

per cent) had polycystic kidneys. At the Albany General Hospital, he found 18 cases with polycystic kidneys in 8,882 necropsies (0.2 per cent), but there were 47 cerebral aneurysms in which 3 cases of polycystic kidneys were also found (6.4 per cent). In Bigelow's own series of 18 patients with polycystic kidneys, 3 were found to have intracranial aneurysms (16.6 per cent); however, no postmortem examination was performed on 6 of the 18, and 4 of the 18 were infants who did not have intracranial aneurysms.

Although the incidence of this type of condition is not so large in the present series, one such case was found in a previous group (Fig. 2). Another case of renal cell carcinoma of the kidney is illustrated (Fig. 3). The knowledge of the pathologic change in the kidneys of these patients influenced their subsequent surgical treatment.

With this in mind, a survey was made of 113 consecutive cerebral angiograms made from January through October, 1962. Of these, 112 showed satisfactory filling of the cerebral arteries, but 10 of the 112 had no KUB film taken.

A Siemen's biplane serial film changer, mounted at the end of an x-ray table, was used for taking the cerebral angiograms. To obtain the KUB film the patient was moved out of the Siemen's head unit downward to place the abdomen over the Bucky tray.

During the period under review, no consistent time had been established for exposure of the KUB film. Immediate evaluation of the cerebral angiograms, repeated injections, and other factors frequently delayed the timing. In some situations the abdominal films were omitted or exposure was delayed after the injection of the dye. Routine radiologic factors relating to the patient's body build were observed in making the films.

There were 102 post-angiographic KUB films, 24 (23.5 per cent) of which were found on subsequent study to be abnormal in some detail.

The source of the greatest difficulty in interpreting the films was not the failure of the dye to be excreted adequately nor the improper preparation of the patient, but improper centering of the patient or improper exposure of the KUB film.

This survey has improved the post-angiographic pyelograms, both in setting a time limit after the injection for the KUB film to be taken and in the routine technique of exposing the films. It was surprising to find the relatively small number of unsatisfactory pyelograms attributable to poor preparation of the patient's gastrointestinal tract.

Discussion

Following cerebral angiography, KUB films should be taken approximately 10 minutes

TABLE 1

SECONDARY PATHOLOGY UROGENITAL SYSTEM

102 Postangiographic KUB films		
24 of 102 had abnormal KUB film (23.5%)		
A. Obstruction:		8
Calculus—	5	
Vascular impingement at uteropelvic junction—	2	
Retrocaval ureter—	1	
B. Mass, intrinsic:		5
Abnormal size or configuration of renal shadow, or both—	3	
Distortion of calyces—	2	
C. Mass, extrinsic:		3
Displacement of kidney—	2	
Displacement of ureter—	1	
D. Pyelonephritis		4
E. Asymmetry of renal size, suggesting renal vascular lesion		3
F. Polycystic disease		1
	Total	24

after injection of radiopaque dye. This will usually give satisfactory visualization of the kidneys, ureters, and occasionally the bladder. A small but significant number of abnormal urograms may be anticipated. These may include neoplasms otherwise unsuspected or renal disease which could influence the treatment of the neurologic disorder. Special care has been taken to obtain detailed KUB films in hypertensive patients as part of the initial investigation. Once the patient is moved down on the table over the Bucky tray, serial KUB films can be made.

Summary

One hundred and thirteen consecutive angiograms have been reviewed, 102 of which had postangiographic KUB films. Although no special attention was given to timing of the films after injection or preparation of the intestinal tract, 24 of the 102 had abnormal films. The incidence of suggested pathologic change in the KUB films is sufficiently high (23.5 per cent) to warrant this test as a part of angiographic procedures when it can be done without detriment to the patient. On subsequent study, a few of the abnormalities will be of major importance.

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3. Spring, M., and Gross, S. W.: Ruptured aneurysm of the circle of Willis associated with polycystic kidneys. Arch Intern Med 102: 806, 1958.

Long term experience with the use of androgens and thyroid for stimulation of growth in short children: Effects on bone maturity and linear growth—A. M. Storment, Jr. (San Francisco), R. F. Escamilla, and A. J. Williams. Ann Intern Med 60:962 (June) 1964.

Ten years of using thyroid and androgens to stimulate growth in short children yielded good results (a puberty-like growth spurt) in 88 patients who were treated for periods of one to six years. Diagnostic categories were: familial short stature, hypopituitarism, and miscellaneous. Average age at start of treatment was 12½ years. Serial bone age determinations showed that bone age and height age increased at the same rate; the former had a tendency to approach but seldom passed chronologic age. Estimates of eventual mature height compared before and after treatment indicated an increase in about a third of the patients. The psychological value of the dramatic effects of treatment appeared in generally improved social and scholastic outlooks. Side effects of virilism (even in girls) and hyperthyroidism were seldom encountered; they were carefully sought and adjustments in dosage were made when necessary. The use of this mode of treatment seems justifiable, if it is properly monitored.

Side effects of long-term treatment with corticosteroids and corticotrophin—B. L. J. Treadwell et al (West London Hosp, London) Lancet 1:1121 (May 23) 1964.

A prospective study of 110 patients with rheumatoid arthritis was carried out from 6 to 111 months to observe the frequency and severity of side effects. Corticosteroids were used continuously in 68 patients and corticotrophin continuously in 60; 18 received each drug at different times, and they were included in each group. In the corticosteroid-treated group the commonest side effects were bruising, mooning, and dyspepsia. With corticotrophin treatment, severe side effects were rare. There were some androgenic effects; 3 of 24 had amenorrhea, and 4 of 60 had acne. Every patient who experienced dyspepsia had received either salicylates or phenylbutazone in addition. Side effects were commoner in women and with the use of corticosteroids, and they increased with duration of treatment and dosage. Neither trend was observed with corticotrophin. Relation of side effects to age was observed with neither drug. The complications caused by corticosteroids rarely warrant withdrawal of the drug.

President's Page



ON ATTENDING CONVENTIONS

Almost ten per cent of the doctors of the United States registered at the Annual AMA Convention in San Francisco. South Carolina was well represented but not nearly 10 per cent of the South Carolina Medical Association membership was in attendance. Sometimes we are prone to wonder whether or not the expense in time and money to attend such a convention is worthwhile. If we would but pause and think, we would realize that the renewal of confidence in ourselves when we are exposed to the latest in medical thinking in all phases of medicine is in itself reason enough to attend.

An annual AMA Session is a three ring circus. There is so much going on that we never know just what to see. The scientific exhibits gave us the latest on muscle relaxants, the best approach to essential hypertension, how to replace a worn joint, or transplant an organ; there was an exhibit to show that the "Battered Child Syndrome" was fact and not fancy and demonstrations on fractures and how to treat a simple fracture that was not simple.

The commercial exhibits caught your attention with their displays and their "pitchmen." You could watch a pantomine or put a telephone to your ear and hear the reasons why vasodilator A was the drug of choice. You might push your way through the largest crowd surrounding an exhibit and catch a glimpse of four well trained Japanese girls stirring powder and liquid in a bowl then passing it from one to the other with bowing and gestures. They are going through their ancient "Rites of Tranquility" the man explains. Then you look around and see that you are in the Miltown booth.

You do not have to be a delegate to go to a meeting of the House of Delegates. There are available chairs in the "Visitors" section where you can hear and see the inside workings of the great organization of medicine. If you want to get down to the heart of things—go to the Reference Committee meetings. Here you can not only sit and see but have your say if you so desire. It gives you a safe feeling to watch the careful and conservative manner in which matters pertaining to medicine are approached and dealt with by the House of Delegates—and that from an organization which is always reaching out into the unknown in their research for answers that prolong living.

The next Clinical Meeting is in Miami in December. You should go—and take your wife—the Auxiliary has a wonderful program arranged.

Frank C. Owens, M. D.

Editorials

Hot Weather Hazard—Creeping Eruption

Creeping eruption, or larva migrans, is a rather broad term referring to infestation of the skin with various larvae. The larval forms of cat and dog hookworm are most common in our part of the country and woe befall the person who, working under a house, or under a car, or just lying on the beach, happens to lie upon a mass of hatching-out larvae, where infested dogs or cats have preceded him.

The larvae enter the unbroken skin and may then proceed to chew their way along the outer layers of the skin without invading the body for completion of the larval stage. They may wander in the skin for months, during which time almost unbearable itching and secondary infection take their grisly toll.

It is possible that insecticides and mosquito control programs, control of fireants, and general spraying with DDT, etc. may have reduced the incidence of this condition greatly in the past few years. But there are still many cases.

When only a few larvae get into the skin, freezing them sufficiently to raise a blister and thereby exfoliate them suffices. Even so, the freezing and blistering are a painful process to the patient, adding insult to the infestation injury. The larvae have a high degree of independence of environment in their invasive stage with an almost impervious cuticle and an ability to live in plain sterile water for sixty days with full motility. It is therefore difficult to get at them with drugs taken internally.

However, in the last days of the 1963 warm season, Drs. Stone and Mullens at the University of Texas in Galveston utilized the drug thiabendazole, which has come to be the best anthelmintic available for trichinosis and roundworms in domestic animals.

They gave it to three patients with extensive creeping eruption which had not responded to any other therapy. The results were dramatic, with relief of itching within twelve hours and subsequent death of all except a few of the larvae. Further testing in Florida on three cases resulted in failure in two of them.

The safety of the medication is borne out by extensive use of the drug in humans in Brazil and Liberia for worm infestation. The drug is given by mouth in tablet form or in a marshmallow suspension. The only side effect is occasional marked nausea and sometimes vomiting. This is not a toxic affect but a cerebral stimulation common to most anthelmintics.

Any method of treatment with some degree of promise will be most welcome in this distressing condition and it is to be hoped that further experience with thiabendazole will be favorable.

John van de Erve, M. D.

The AMA Meeting in San Francisco

The reports of the activities of this very successful meeting will have appeared by now in the *AMA News* or other official publications of the Association. There were no obvious spectacular developments visible to one on the sidelines. The subject of equal racial rights was again discussed and all members of the AMA were urged to promote equality in medical affairs. The physician-hospital relationship was under discussion and the profession was urged to assume responsibility. Studies were instituted on the subjects of continuing medical education and the cost of medical care. A proposal that the membership be polled on the subject of social security for physicians was rejected.

The House of Delegates condemned cigarettes as a "serious health hazard," thereby putting them in the same class with automobiles. As Dr. Edward Annis completed his term as president, it was voted that he be employed as a mouthpiece for the Association and used in various speaking capacities.

The House made a vociferous and cheerful

acknowledgement of the news that "Medicare" had been retained in the Ways and Means Committee and would probably not come to the floor of the Congress this year. Pessimists opined that something similar might be tacked on to some other bill and pushed through before there was adequate opportunity to present proper opposition.

Our own delegates were present and active. Dr. Joseph Cain, Chairman of the Reference Committee on Amendments to the Constitution and By-Laws presented a report which was accepted in toto by the House.

Canada and Compulsory Insurance

In mid-June an all-out scheme for compulsory health insurance was presented by the Royal Commission on Health Services, and an early fullblown conference between Canadian federal authorities and provincial (i. e. state) authorities was recommended. The commission distinctly rejected "state medicine" and proposed a compromised division of responsibility between the federal and provincial authorities.

The proposal as it stands far exceeds the famous Saskatchewan arrangement. It includes payment for drugs, dental care, optical services, care of crippled children, and retarded children, home care and other benefits. The proposal differs from that of current schemes in the United States in that it recommends that the program be handled through existing health insurance agencies. Free choice of physicians was stipulated and freedom of choice of location was assured to the physician.

It was estimated that the cost of such a program would run to 466 million dollars by 1971 or $20 for each person in the country. All forms of means tests were frowned upon. Funds to support the program are to be raised, not through social security arrangements, but through general taxation of unspecified kind.

It is anticipated that the Canadian Medical Association will offer strong opposition to the suggested arrangement.

From Mass. to Miss.

The following dubiously necessary exhortation has come to hand. Suspicion seems to have spread itself even over the medical profession.

June 30, 1964

Dear Doctors:

For the past two weeks we have been caring for several hundred American college students preparing themselves in Ohio for a summer's work in Mississippi. We have treated a variety of medical complaints ranging from lacerations, sprains, infections and allergies, to an acute surgical abdomen warranting emergency hospitalization.

We fully understand that the activities of these students working for civil rights in Mississippi may be strongly resisted by many people of the state. As physicians we are concerned that they continue to receive adequate medical care.

We are hopeful that the doctors of this nation, wherever they live, whatever their social or political views, will respond fully and without reservation to the words of the Hippocratic oath: "The regimen I adopt shall be for the benefit of my patients according to my ability and judgment, and not for their hurt or for any wrong . . ."

We are sending this short letter to our fellow physicians of Mississippi and to the county medical societies, in the sincere hope that a clear separation between social upheaval and medical need will be maintained.

Sincerely,
Joseph H. Brenner, M. D.
Medical Department
Massachusetts Institute of Technology
Robert Coles, M. D.
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June 18, 1964

Senator T. Allen Legare, Jr.
63 Broad Street
Charleston, South Carolina

Dear Senator:

The Charleston County Medical Society quite respectfully declines to nominate, at this time, candidates from its membership to the Community Mental Health Board.

Although the Society deeply appreciates the courtesy shown them by the county legislative delegation when it was asked by the delegation to nominate candidates to the board, recognizes the need for maximum medical representation on the board and sincerely desires to participate fully in the orderly expansion of mental health facilities and improvement of the care of the mentally ill and the insane of the community, the Society must continue to point out that the Community Health Services Act of the State of South Carolina has not, as yet, been fully amended, as urged by this Society, to adequately protect the best interest of our patients of the general community and therefore the Society cannot in good conscience participate in the implementation of that act.

Specifically, the act has not been amended by the legislature to make it mandatory that the overall director of these individual community mental health clinics be a qualified fully trained psychiatrist, when available, or, at least when a psychiatrist is not available, a doctor of medicine licensed to practice in the State of South Carolina.

As the act is now written, a layman or an individual in some para-medical field, such as a social worker or a psychologist, could conceivably be appointed director of a community mental health clinic and it is the belief of the Charleston County Medical Society that this would not be in the best interest of our patients or in the best interest of the community or the state.

The Charleston County Medical Society has made its position clear on this matter to the Charleston County Delegation in the past. The South Carolina Medical Association has, likewise, through its committee on mental health, stressed to the state legislature the need for the addition of an amendment to the Community Mental Health Services Act as mentioned above. It is the sincere hope of the Medical Society that such an amendment to the act will be presented and passed in the next session of the legislature.

The Charleston County Medical Society does not intend that its present refusal to officially participate in the formation of the Community Mental Health Board shall either prohibit its members from membership on that board as individuals or preclude further appointment to the board of members of the Society by the County Delegation, if the Delegation so desires; nor does the Society wish that its action be construed as lack of interest in or disapproval of the establishment of the Community Mental Health Board.

Yours very truly,
Clay W. Evatt, M. D.
President, Charleston County Medical Society

June 17, 1964

The Editor:

The following letter from Dr. Wyman King of Batesburg has been received. I believe that the statement of his experience as a member of the State Board of Nurses of South Carolina should be given publicity equal to that given to my article referred to by him.

With Dr. King's permission, I offer his letter for publication.

J. Decherd Guess, M. D.

Dear Dr. Guess:

I have carefully read your article, Nursing Education Today, Role of the South Carolina Board of Nursing, which appeared in a recent issue of *The Journal*. It is obvious that you have given this matter careful study.

This letter is not intended to be critical. It is my belief, that if a greater number of better, or even equally, qualified nurses can be produced by simplifying the laws and eliminating some of the responsibilities that the Board now has, the change will be a welcome one.

The statement you made, namely, that the two physician members of the Board have "at times been made to feel that they were merely tolerated rather than that their opinions were worthy of discussion or consideration," leads me to believe that someone has misinformed you. Your statement is definitely contrary to the attitude toward me, since I have been a member of the Board.

Many times my advice has been sought, not only at the meetings, but also at times by telephone or mail. I, therefore, do not wish to be excluded when there is criticism. In fairness to all you should have this information.

W. Wyman King

MINUTES OF COUNCIL SOUTH CAROLINA MEDICAL ASSOCIATION MYRTLE BEACH, S. C., MAY 5, 1964

The first meeting of Council, in conjunction with the 116th Annual Session of the South Carolina Medical Association, was called to order at 9:00 a. m. May 5, 1964 by the Chairman, Dr. A. F. Burnside, in the Woodside Room at the Ocean Forest Hotel, Myrtle Beach.

Those attending were Dr. Robert Wilson, President; Dr. Frank C. Owens, President-Elect; Dr. Asbury C. Bozard, Vice-President; Dr. J. Howard Stokes, Treasurer; Dr. Joseph I. Waring, Editor of the Journal; Mr. M. L. Meadors, Executive Secretary and Counselor; Dr. George Dean Johnson, Delegate to AMA; Dr. Joseph P. Cain, Jr., Delegate to AMA; Dr. J. Arthur Siegling, President of the South Carolina Medical Care Plan; Dr. John M. Pratt, (Recorder), and Councilor from the Fifth District, who served in the absence of Dr. Ben N. Miller, Secretary; Dr. Clay W. Evatt, Councilor from the First District; Dr. A. F. Burnside (Chairman), Councilor from the Second District; Dr. C. J. Scurry, Councilor from the Third District; Dr. John P. Booker, Councilor from the Fourth District; Dr. William L. Perry, Councilor from the Sixth District; Dr. Norman O. Eaddy, Councilor from the Seventh District; Dr. Joseph D. Thomas, Councilor from the Eighth District; and Dr. John M. Fleming, Councilor from the Ninth District.

The first order of business was a report by Dr. O. B. Mayer, Chairman of the committee appointed by Council to investigate possible sites for a permanent home for the South Carolina Medical Association. Dr. Mayer gave a description and exact location of a property on Bull Street in Columbia which the committee felt would be desirable, and the offering price for the purchase of this property was suggested as $65,000.00. Several commented on this report. Dr. Cain, for one, expressed a desire to postpone any action by Council until after the financial report was received.

Dr. Burnside asked Dr. Stokes to give the Treasurer's Report. This report was discussed, and Dr. Stokes answered various questions. He also pointed out that the Association is operating with a deficit of $20,000.00. Ten thousand of this has been paid back from 1964 receipts, and there remains ten thousand to be paid to the bank. He suggested the possibility of withdrawing $20,000.00 from the invested Mutual Funds (approximately $74,000.00 now invested in Mutual Funds), and placing this in general funds to take care of last year's deficit plus this year's deficit totaling $20,000.00. The rate of interest that is being paid on the borrowed money was established, and the discussion continued. Dr. Owens commented that he felt that this was a feasible plan. Dr. Stokes also discussed the possibility of increasing dues, and stated that this could be considered on the basis that expenses will not go up any appreciable amount, and dues have not been raised in a long time. He also pointed out that state dues are among the lowest in the southern states. Dr. Wilson questioned the advisability of withdrawing money from what seemed to be a sound investment (Mutual Funds) for the sake of having a cash balance in the bank. Mr. Meadors stated that operating funds pick up about April and May, then begin to run low about November and December. Each member present was furnished a report on investments, including Mutual Funds and Savings and Loan Association, showing dividends reinvested, etc. Mr. Meadors gave an estimate of the percentage of dividends paid on stocks (including dividends and increase in value), and savings, figured on a five year basis. Dr. Owens felt that serious consideration should be given to raising dues.

The discussion reverted back to the Permanent Home Committee report, and Dr. Wilson commented than any action taken on this should be recommended to the House of Delegates.

Dr. Stokes suggested that a committee be appointed to study the financial situation.

Dr. Evatt moved that the Treasurer's Report be accepted as information. Motion was seconded by Dr. Pratt, put and carried.

Dr. Owens moved that Council approve the utilization of $20,000.00 to be withdrawn from accumulative funds to pay off the outstanding debts, and that a committee be appointed to consider the raising of dues if necessary for the passage of such action by the House of Delegates.

Dr. Burnside asked if there were any objections. Dr. Wilson pointed out that he would be opposed to liquidation of invested assets just for the sake of paying off $10,000.00

Dr. Owens withdrew the motion, and Dr. Stokes presented a modified motion that the financial situation remain as it is, and that a committee be appointed by Chairman of Council to consist of three (3) members of Council, with the Chairman of Council, Treasurer, and Executive Secretary, ex-officio, to study the finances of the South Carolina Medical Association, consider the possibility of raising dues, and to report to Council with their recommendations at the fall meeting. This motion was seconded by Dr. Pratt, put and carried.

Dr. Mayer reopened the discussion on the permanent home. Dr. Owens commented on the desirable location of the property, including parking facilities, its location in relation to the State House, etc. Dr. Owens then moved that the accumulated (estimated $49,000.00) now in the Building Fund be utilized to purchase the previously described property on Bull Street in Columbia, and that the President, Treasurer,

and Secretary be authorized to carry out this purchase, and further authorized to negotiate a mortgage of $25,000.00 with the balance left over beyond the purchase price to be used for repairs, furniture, and furnishings. This motion was seconded by several. Dr. Eaddy opened the discussion and commented that he would suggest waiting for a report from the committee which will be appointed to study the finances of the Association. After considerable discussion, Dr. Burnside asked for a decision on Dr. Owen's motion. The motion was put before Council and passed by majority vote 7 to 4. Action of Council on this motion to be presented to the House of Delegates.

Dr. Eaddy moved that Mr. Meadors be asked to check on the Delegates from the County Medical Societies referable to the requirement of being affiliated with the South Carolina Medical Association, as set forth in the Constitution and By-Laws. This motion was seconded by Dr. Thomas, put and carried.

The next item of business was a report from Dr. Joseph I. Waring, Editor of the *Journal*. Motion was made by Dr. Eaddy that Council accept the report and compliment Dr. Waring on the excellent work. The motion was seconded by Dr. Evatt, put and carried.

Dr. Waring also gave a report on Public Relations activities. Dr. Wilson moved that the report be accepted and that the Charleston County Medical Society be commended on their fine work and support of medical publications. This was seconded by several, put and carried. The Secretary was directed to send such a letter.

Public Relations

Public Relations activities during the year have centered largely upon the annual institute held in Columbia in February and with a series of meetings and negotiations with the South Carolina Hospital Association, Blue Cross - Blue Shield, and commercial insurance. Consideration of the last named has been handled by the special committee of the Association appointed to deal with this matter. A number of meetings were held with the other organizations and out of them there has seemed to come a much improved feeling of mutual concern and cooperation. With the first two organizations, the Association shared financially and otherwise in the project for preparing, printing, and distributing through the hospitals 100,000 brochures dealing with the Kerr-Mills Act and its provisions. Blue Cross furnished us copies of reprints of the speech of Congressman Laurence J. Burton of Utah from the *Congressional Record*, in which the King-Anderson Bill was discussed. These were distributed as widely as possible.

I have prepared a number of articles for the newspapers which were well received and have attempted to stimulate the secretaries and public relations representatives over the state to carry on local activity. This has been fruitful in a number of places. I would like to cite as an example of desirable activity what has been done by the Charleston Society. Its activities included paid newspaper advertising, paid radio announcements, paid support of a national commentator's program on radio, direct mailings of reprints of the advertisements in the newspapers to members of civic clubs, professions, and other groups in the Charleston area, showing of a 25 minute AMA movie on television, and arranging speakers before sixteen civic clubs, with more to come. The Aiken County Society and others have also run paid advertisements in the newspapers. Copies of the Charleston advertisement were sent to all of the county societies with the suggestion that they might support something of the same kind.

Working with Blue Cross - Blue Shield, I have tried to stimulate an interest in the four largest societies of the state in staging a meeting at which high school debating teams might discuss the subject of medical care. This was for the purpose of affording some recognition of the importance of the subject to young people. This project is still in the stage of discussion by the societies.

I have answered a number of inquiries and furnished pamphlets prepared by the AMA to a number of people who have requested them.

During the year three books dealing with the problem of medical care, obtained from the AMA, were sent to each of the public libraries of the state as sources of reference for local inquirers.

I have prepared releases for the daily newspapers of the state and a few weeklies concerning the annual meeting and arranged for coverage by several newspapers and the Associated Press.

Last year the president set up a statewide public relations liaison or contact committee which was intended to provide us with a list of people to whom we could write or call and ask for support of any local public relations activities. Only sixteen members accepted the appointment to this committee, but they have been helpful and I would like to suggest that the new president consider appointing again one of the delegates from each county as a local contact. The committee would not be required to meet or to do anything other than try to further the general effort at public relations on a local level.

Dr. Waring then reported on the publication "History of Medicine In South Carolina," stating that approximately 650 copies of the book had been mailed out on request, and a few others mailed to known interested people. More recently approximately 160 books have been sold; however, there are still about 620 books on hand, and he asked Council to let him know what should be done about the books on hand. The purchase price of the book is $7.50. Dr. Fleming moved that this matter be left to Dr. Waring's judgement, seconded by Dr. Eaddy, put and carried.

Dr. Peeples, representing SCALPEL, did not give his report at this time, but it was decided to postpone this until after he meets with Dr. Pratt and members from various Districts at a meeting arranged by Dr.



Dr. Norman Eaddy, New Chairman of Council

Pratt at 5:00 p. m. Dr. Wilson will also be present at the meeting.

Dr. James H. Gressette, Chairman of the Special Committee on Nursing Education, appeared before Council and stated that he had nothing further to report since the last meeting. His committee has had no further meetings, and the report remains the same as when it was presented in February, 1964. Dr. Eaddy moved that this committee be requested to continue their work and when they have something to report, they should feel free to bring this before Council. Dr. Pratt seconded the motion; however, the motion was withdrawn by Dr. Eaddy, and Dr. Cain moved that this be accepted as an interim report, and referred to the House of Delegates. Dr. Johnson seconded the motion. The motion was put and carried.

Dr. John M. Pratt, Recorder, acting in the absence of the Secretary read a report from the Committee on Tetanus Immunization. Dr. Wilson moved that this report be approved by Council and recommended to the House of Delegates. The motion was seconded by Dr. Cain, put and carried.

A report was given by Dr. Clay W. Evatt, chairman of the Committee to Study Health Organizations seeking Endorsement by the State Medical Association. The report is quoted:

"Our committee voted to endorse Medic-Alert.

Some of the committee, though reluctant to give a blanket endorsement of the National Foundation, still feel that we should express a willingness to advise the Foundation and help direct its activities in the state. So far as we know, neither the AMA nor any state associations have given a blanket endorsement to the Foundation."

Dr. Cain moved that this report be accepted as information and referred to the House of Delegates. The motion was seconded by Dr. Booker, put and carried.

Dr. Joseph P. Cain, Jr., Chairman of the Special Committee on Medical and Hospital Insurance Contracts gave an informal report for information. Dr. Evatt officially thanked Dr. Cain for the report. No action was taken.

Council went into executive session for the discussion of certain matters, during which no action was taken to be reported on resumption of regular session.

Dr. John M. Pratt, Recorder, read a communication from Dr. Edward E. McKee, Professor of Pathology, Medical College, Charleston, S. C., and Chairman of the Committee on Cancer. Dr. Wilson moved that this communication, referable to the establishment of a special section of pathology, be referred to the Committee on Postgraduate Medical Education, and that the Secretary notify Dr. McKee of this action. The motion was seconded by Dr. Johnson, put and carried.

Dr. Frank Owens requested that he be relieved of Chairmanship of the Medical Advisory Committee to Selective Service since he will be taking over the Presidency of the South Carolina Medical Association at this time Dr. Eaddy moved that Dr. Owens remain as Chairman of this committee if he will accept. This was seconded by Dr. Perry, put and carried.

As President of the South Carolina Medical Care Plan, Dr. J. A. Siegling asked Council to accept the list of names submitted by the Nominating Committee for election to the Board of Directors. Dr. Cain moved that Council accept the slate of nominations as submitted. This was seconded by Dr. Johnson, and Council so nominates the following:

A. C. Bozard, M. D., Box 489, Manning, S. C.

Charles J. Lemmon, Jr., M. D., 2005 Hampton Street, Columbia, S. C.

Luther M. Mace, M. D., 34 Wren Street, Barnwell, S. C.

Mr. A. P. Nisbet, Administrator, Self Memorial Hospital, Greenwood, S. C.

Mr. Thomas C. Vandiver, President, Southern Bank & Trust Co., Greenville, S. C.

Mr. Raymond Pridgen, Attorney at Law, Mullins, S. C.

Mr. Meadors reported that Mr. Whitaker had asked that Council again approve the A. A. P. S. Essay Contest and appropriate the funds ($125.00) for this. This was put in the form of a motion that the sponsorship be approved, seconded by Dr. Bozard, put and carried.

Mr. Meadors reported on a communication from General Council of AMA referable to physicians with financial interests in the repackaging of drugs, etc. Dr. Owens commented on what Columbia Medical Society has done so far in regards to this matter. Dr. Owens moved that this be referred to the County Medical Society where the situation exists for investigation. Seconded by Dr. Evatt. The motion was put and carried.

Mr. Meadors next gave the Executive Secretary's Report prepared for the House of Delegates. Dr. Johnson moved that the Executive Secretary's Report be now accepted by Council. This was seconded by Dr. Booker, and others, put and carried.

Dr. Booker commented on the matter of licensure reciprocity with other states. This was discussed, and Dr. Cain moved that a member (Dr. Jervey) of the State Board of Medical Examiners be invited to the

Council meeting on Wednesday, May 6 to discuss this further. The motion was seconded by Dr. Booker, and carried. The Executive Secretary was instructed to arrange this.

As designated in the Constitution and By-Laws of the South Carolina Medical Association, certain nominations must come from Council to be voted upon by the House of Delegates. The floor was now open for nominations. Council action as follows:

(1) Treasurer:
Dr. J. Howard Stokes was nominated by Dr. Evatt, seconded by Dr. Eaddy. Nomination was unanimous.

(2) Legislation and Public Relations Committee:
Dr. Donald G. Kilgore and Dr. C. Tucker Weston were nominated by Dr. Owens to succeed themselves, seconded by several. Nomination was unanimous.

(3) Emergency Medical Care Committee:
Dr. J. Graham Shaw was nominated by Dr. Booker to succeed himself, seconded by Dr. Thomas. Nomination was unanimous.

Dr. Owens moved that the Councilors from the Second, Fifth, and Eighth Districts make recommendations to Council on Wednesday, May 6 for nominations of Members of Mediation Committee. The motion carried.

Council adjourned the meeting.

Ben N. Miller, M. D.
Secretary

MINUTES OF COUNCIL
MYRTLE BEACH, S. C., MAY 6, 1964

The second meeting of Council, in conjunction with the Annual Session of the South Carolina Medical Association, was called to order at 8:30 a. m. by the Chairman, Dr. A. F. Burnside, on May 6, 1964 in the Woodside Room at the Ocean Forest Hotel, Myrtle Beach, South Carolina.

Those present were Drs. Wilson, Owens, Bozard, Stokes, Waring, Johnson, Cain, Siegling, Evatt, Burnside, Scurry, Booker, Perry, Eaddy, Thomas, and Mr. M. L. Meadors.

Dr. John M. Pratt, Dr. John M. Fleming, and Dr. Ben Miller were absent.

Council received officers of the Woman's Auxiliary; namely, Mrs. Ralph P. Baker, President; Mrs. C. B. Burns, incoming President; and Mrs. L. H. Taylor, Jr., Treasurer. Representing the Auxiliary, they made an expression of appreciation to Council, and were officially welcomed.

Dr. Burnside asked for nomination of Members of Mediation Committee. Council to nominate two people from the Second, Fifth, and Eighth Districts. Action of Council as follows:

Second District
Dr. R. G. Latimer, Cayce, S. C.
Dr. George A. Poda, Aiken, S. C.
Fifth District
Dr. R. W. LaRoche, Camden, S. C.
Dr. John N. Gaston, Jr., Chester, S. C.
Eighth District
Dr. James L. Wells, Orangeburg, S. C.
Dr. Henry W. Gibson, Barnwell, S. C.

It was concluded that Dr. John P. Booker should interrogate the Secretary of the State Board of Medical Examiners referable to licensure reciprocity and determine how these agreements are brought about.

Council adjourned until Thursday, May 7, 1964.

Ben N. Miller, M. D.
Secretary

MINUTES OF COUNCIL
MYRTLE BEACH, S. C., MAY 7, 1964

The final meeting of Council, in conjunction with South Carolina Medical Association Annual Meeting, was held on the concluding day of the State Meeting, May 7, 1964 at 8:15 a. m., Ocean Forest Hotel, Myrtle Beach, South Carolina. Dr. A. F. Burnside, retiring Chairman of Council, presided.

The following members were present: Dr. Clay W. Evatt, Councilor, First District; Dr. A. F. Burnside (Chairman), Councilor, Second District; Dr. William L. Perry (Vice-Chairman), Councilor, Sixth District; Dr. Norman O. Eaddy, Councilor, Seventh District; Dr. Joseph D. Thomas, Councilor, Eighth District; Dr. Frank C. Owens, President of S. C. M. A.; Dr. A. C. Bozard, Vice-President (retiring); Dr. Swift C. Black, newly elected Vice-President; Dr. Ben N. Miller, Secretary; Dr. Joseph I. Waring, Editor of the *Journal;* Mr. M. L. Meadors, Executive Secretary and Counselor; Dr. Joseph P. Cain, Jr., Delegate to AMA; and Dr. Wyman King, newly elected Councilor of the Second District.

The following were absent: Dr. John M. Fleming, Councilor, Ninth District, who communicated with Dr. Burnside, indicating an emergency call home; Dr. C. J. Scurry, Councilor, Third District; Dr. John P. Booker, Councilor, Fourth District; Dr. R. Macdonald, newly elected Councilor of the Fifth District; Dr. Julian Price, President-Elect; Dr. J. Howard Stokes, Treasurer; and Dr. George Dean Johnson, Delegate to AMA.

The first item of business was a report from Dr. Perry. Dr. Horace M. Whitworth, Jr. of Greenville, Chairman of the Committee on Maternal Health of South Carolina Medical Association, reports difficulty in getting facts on maternal deaths from attending physicians. Dr. Joe Waring commented on this problem, also on the committee's recent report. Dr. Burnside reported that Dr. Hilla Sheriff of the State Board of Health, had suggested that maternal deaths

be reported by wire to the State Board of Health.

A motion was made by Dr. Joe Waring that the State Board of Health take under advisement the idea of requesting reports on maternal deaths by wire within 24 hours after the patient expired. This motion was seconded by Dr. Perry. The motion was discussed by Dr. Joe Cain, put, and carried.

Dr. Joe Waring moved that the Ad Hoc Committee on Public Health Information, with Dr. Louis P. Jervey, Chairman, be granted additional monies for its activities. The motion was to grant an additional $500.00. Dr. Bozard seconded the motion. The motion was put and carried.

Mr. Meadors reported on the problem of the 1965 Annual South Carolina Medical Association Meeting. The House of Delegates had voted to hold this meeting in Myrtle Beach, and the Ocean Forest Hotel is available for the week of May 4, 5, and 6, 1965. It was moved by Dr. Eaddy, seconded by Dr. Owens, that finalization of this date be left with the President, Dr. Frank Owens, and Mr. Meadors. The motion was put and carried.

Dr. Harrison Peeples spoke in behalf of SCALPEL. Directors of SCALPEL ae now to be appointed by Council. Dr. Peeples presented the following names and these were appointed by Council: First District: Dr. L. L. Brown, Charleston, and Dr. Harrison L. Peeples, Estill. Second District: Dr. C. Tucker Weston, Columbia, and Dr. C. B. Burns, Sumter. Third District: Dr. Joel W. Wyman, Anderson, and Dr. J. S. Garrison, Johnston. Fourth District: Dr. Donald G. Kilgore, Jr., Greenville, and Dr. Michael F. Patton, Spartanburg. Fifth District: Dr. John M. Pratt, York, and Dr. William E. Simms, Jr., Lancaster. Sixth District: Dr. Howard H. Poston, Jr., Kingstree, and Dr. N. B. Baroody, Florence.

Under the heading of organization of Council, Dr. Clay Evatt had a word of commendation for the excellent and faithful work of Dr. Burnside.

Dr. Clay Evatt nominated Dr. Norman O. Eaddy for Chairman of Council. This was seconded by several. Dr. Perry moved that the nomination be closed and that Dr. Eaddy be elected by acclamation. He was so elected.

Dr. William L. Perry was nominated for Vice-Chairman by Dr. Bozard. Dr. Evatt moved that the nomination be closed and that Dr. Perry be elected by acclamation. Action so taken.

Dr. Perry nominated Dr. Wyman King, newly elected Councilor from the Second District, for Recorder. Nomination was seconded by Dr. Bozard, and Dr. King was elected.

The meeting was turned over by Dr. Burnside to the newly elected Chairman of Council, Dr. Eaddy. Dr. Eaddy had some brief remarks on becoming Chairman. At the conclusion of this, Council adjourned.

Ben N. Miller, M. D.
Secretary

News

Dr. Brackett Joins Greenville Firm

Dr. N. C. Brackett became associated with Dr. William W. Pryor and Dr. A. G. Meakin in the practice of internal medicine on July 1.

Dr. Brackett, a native of Pickens, was graduated from Clemson College in 1949. Following service in the U. S. Air Force, he attended the Medical College of South Carolina, receiving his degree in 1959.

He received post-graduate training as an intern at the North Carolina Memorial Hospital in Chapel Hill, N. C., where he also served as assistant resident and resident in medicine.

During 1962-64,, he was a Fellow in medicine at Tufts University School of Medicine, New England Center Hospital, Boston, Mass.

Dr. Thomas B. Warren at Allendale

Dr. Thomas B. Warren, Jr., has begun his practice of medicine in Allendale, being associated with Dr. H. L. Lafitte.

A native of Allendale, Dr. Warren has just completed two years of active duty in the Army. While he was stationed at MacDonald Army Hospital, Fort Eustis, Virginia, he worked on the pediatrics service for a year. He spent the past thirteen months in Korea, where he was stationed at the 121st Evacuation Hospital on the surgery service and at the 543rd General Dispensary in Taegu.

Dr. Warren graduated from Presbyterian College in 1957, where he was a member of Pi Kappa Alpha social fraternity. After graduating from the Medical College of South Carolina in 1961, he interned at the Columbia Hospital of Richland County. He is a member of the American Medical Association.

Dr. J. A. Siegling Re-elected To Head Blue Shield

Dr. John Arthur Siegling of Charleston was re-elected president of the South Carolina Medical Care Plan at the quarterly meeting of its directors held in Columbia.

The South Carolina Medical Care Plan is the states' Blue Shield organization.

Other officers re-elected are Dr. R. Cathcart Smith of Conway, vice-president; Dr. Charles J. Lemmon, Jr. of Columbia, secretary, and Thomas C. Vandiver, president of the Southern Bank and Trust Company of Greenville, treasurer.

Raymond Pridgen, lawyer and former mayor of

Mullins was elected a director. Dr. Norman O. Eaddy of Sumter, chairman of the council of the South Carolina Medical Association and Dr. Frank C. Owens of Columbia, president of the South Carolina Medical Association, became ex-officio members.

Board members re-elected are Dr. Luther M. Mace of Barnwell; Dr. A. C. Bozard of Manning; and A. P. Nisbet, administrator of Self Memorial Hospital, Greenwood.

State Board of Medical Examiners

The State Board of Medical Examiners of South Carolina met in Columbia, on June 16, 1964. Physicians applying for medical licensure by endorsement of credentials were interviewed and 15 physicians were licensed to practice Medicine and Surgery in the State of South Carolina. They are as follows:

Dr. Henry Simon Campell is a 1960 graduate of Duke and endorsed from North Carolina. He served a residency in ophthalmology and is currently in the U. S. Army at Fort Jackson.

Dr. Rodney Fitzgibbon graduated from the University of Arkansas in 1955. He is licensed in Arkansas and is board certified in obstetrics and gynecology. He is in practice in Columbia.

Dr. Robert Miller Harris, Jr. is a '59 graduate of West Virginia and is licensed in West Virginia. He is board eligible in general surgery and practices in Hartsville.

Dr. Guy Carlisle Heyl, Jr., a 1954 graduate of the University of Virginia, is licensed in Va., Ga. and Ill. He is board eligible in orthopedic surgery and will begin practicing in Aiken in July.

Dr. Thomas Wellington Howell, a graduate of Jefferson, '37 is licensed in New Jersey. He is board eligible in internal medicine and is currently in the U. S. Air Force at Shaw AFB.

Dr. Lawrence Ronald Hurst is a '57 graduate of Duke and is licensed in North Carolina. He is board eligible in otolaryngology. He is in practice in Spartanburg.

Dr. Richard Emory Lowrey, Jr. graduated from the University of Louisville in 1959 and was licensed in Ky. He is board eligible in anesthesiology. Currently in the U. S. Navy in Charleston, he plans to practice in Sumter in August.

Dr. Robert Edgar McCall, Jr. graduated from Jefferson in 1936. He is licensed in North Carolina and Tennessee. He is board certified in general and thoracic surgery and is currently with the V. A. Hospital in Columbia.

Dr. James Oscar Morphis, Jr., a '58 graduate of Duke, is licensed in North Carolina. He is board certified in pediatrics and practices in Hartsville.

Dr. Romulus Buckland Thomas graduated from the University of Illinois in 1956 and is licensed in Illinois. He is board eligible in psychiatry. He is currently in the U. S. Army at Fort Benning, Ga. and plans to locate in Columbia after the first of September.

Dr. George B. Walton, Jr., a graduate of Duke in 1956, is licensed in North Carolina. He served a residency in radiology and practices in Whiteville, N. C.; and he will do some practice in Conway.

Dr. James Hough Weston graduated from Alabama in 1956 and has a license in Alabama. Dr. Weston completed a residency in obstetrics and gynecology at the Columbia Hospital and now practices in Columbia.

Dr. Frances Pritchett Woodward is a '60 graduate of Alabama and is licensed in Ala., Pa. and Ky. She is beginning her last year of residency training in ophthalmology at the Medical College Hospital in Charleston.

Dr. William Grady Akins, Jr. graduated from Tulane in 1963 and is licensed in La. Dr. Akins has completed his internship and is in the practice of orthopedic surgery in Florence.

Dr. Nicholas Fred Atria is a '32 graduate of Tulane and is licensed in N. J. and Tenn.; and has a certificate of the National Board. Dr. Atria is on the staff of the Palmetto State Hospital at State Park.

Pediatric Society To Meet

The Annual Scientific Meeting of the South Carolina Pediatric Society will be held at Adventure Inn, Hilton Head Island, September 11-13, 1964.

50-Year Membership Pin

A 50-year membership pin has been presented to Dr. W. C. Mays of Fair Play.

International Congress on Diseases of the Chest

Physicians from more than 50 countries will present papers and discuss the recent advances in cardiovascular and pulmonary diseases at the VIII International Congress on Diseases of the Chest to be held in Mexico City, October 11-15, 1964.

For further information write to the American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois, 60611.

UDC Honors Dr. Mole

Dr. J. W. Mole, dean of the doctors of Hampton County, who has practiced general medicine in Brunson since getting up there in 1904, has received the "Cross of Military Service" from the James W. Moore Chapter of the United Daughters of Confederacy.

Deafness Research Foundation Chairman Chosen

Dr. Richard W. Hanckel, Charleston otolaryngologist, has been appointed South Carolina State Chairman of the Deafness Research Foundation.

Southeastern States Cancer Seminar

Robert Meyer Hotel Jacksonville, Florida
November 11-12, 1964

Medical Television

A re-run of the TV Program for Physicians on the subject of Strokes will be given on channel 7, Charleston, and channel 29, Greenville, August 24, at 8:30 p. m. Guest speakers are Dr. Clark Millikan, Chief, Section on Neurology, Mayo Clinic, and Dr. Thorpe Ray, Professor of Medicine, University of Missouri School of Medicine.

Nursing Liaison Activities in State Medical Societies

A questionnaire for the purpose of eliciting information on liaison programs and activities with nursing groups was forwarded to 52 state societies. Fifty (96%) of the societies responded. Forty-one of the 50 respondents (82%) presently maintain liaison with the nursing profession in their state. It is important to note that nine states, including several with a high percentage of nurse and physician population, evidently have no forum for the exchange of ideas or for joint effort. (From *JAMA*, 188:692, May 18, 1964.)

Dr. Wilson Elected

Dr. Richard S. Wilson is the newly-elected chairman of the medical staff of Spartanburg General Hospital.

Dr. John E. Keith is chairman-elect.

Dr. Shaul Named Health Department Aide

Dr. John F. Shaul, USN (ret.), has assumed the position of assistant director of the Charleston County Health Department.

A former Charleston resident, the retired Navy captain will succeed Dr. W. W. Seymour who resigned last December. Dr. Shaul's retirement from the Navy became effective June 1.

Immediately prior to accepting his new position, he was senior assistant medical officer at the U. S. Naval Academy at Annapolis, Md.

He will also have the title of director of preventive medicine.

A native of Bloomfield, N. J., Dr. Shaul was stationed in Charleston as head of the pediatric department of the Naval Hospital from 1959-63 and as chief of dependent services from 1961-63.

A graduate of Lafayette College in Easton, Pa., he received his medical degree from New York Medical College and interned for two years at New York City Hospital and in the Children's Medical Service department of Bellevue Hospital.

He served his residency at Essex County Isolation Hospital, Belleville, N. J. and at the Children's Hospital in Washington, D. C.

Dr. Shaul was certified by the American Board of Pediatrics in 1941, is a fellow of the American Academy of Pediatrics and is the author of numerous medical papers.

Dr. Falls Harris Opens Practice in Greenville

Dr. Falls L. Harris has begun the practice of dermatology at 607 Arlington Avenue.

Dr. Harris is a native of North Carolina and attended the University of North Carolina as an undergraduate. He is a graduate of the university's medical school.

His internship and residency were served at the university of Arkansas Medical Center in Little Rock, Ark.

Physician Plans Enoree Practice

After being without a physician four and a half years, Enoree will have a new doctor as soon as Dr. Otis Hill of Sumter completes his internship at Spartanburg General Hospital in August.

Dr. Hill is a graduate of the Medical College of South Carolina.

State Health Staff Members Earn Degrees

Five staff members of the State Board of Health have returned to their positions after receiving the Master of Public Health degree at the end of this school year. They are Dr. E. Kenneth Aycock, Dr. John Boulware and Carl Fox, all of Columbia, Max Poteat of Spartanburg, and George Swearingen of Aiken.

Dr. Aycock, assistant director of the Maternal and Child Health Division, was awarded the M. P. H. degree by Harvard University on June 11. While at Harvard, his studies were primarily centered in preventive health measures for infants and children. As further recognition for academic achievement Dr. Aycock received a Harvard Key to the School of Public Health. A native of Pinewood, he received his A. B. degree from Duke University in 1950 and his M. D. degree in 1954 from the Medical College of South Carolina where he was a member of the Alpha Omega Alpha honorary fraternity.

Dr. Boulware, assistant to the director of the Division of Disease Control, received his M. P. H. degree from the University of California. A native of Kershaw County, he had attended the University of South Carolina and Washington University in St. Louis and had received his M. D. degree from the Medical College of South Carolina.

Doctor Will Visit Bethune

Dr. Leon Hunt of Bishopville will hold office hours in Bethune on Mondays, Tuesdays, Thursdays and Fridays of each week, beginning at 5 p. m. He will be at the Truesdell Clinic on South Main Street.

Meanwhile, the town's "Doctor Committee" is continuing their efforts to encourage a physician to locate in Bethune on a full-time basis.

Dr. Steuer, Jr. Certified

Dr. Rudolph R. Steuer, Jr., of Gaffney, has been certified by the American Board of Pathology.

in the overweight stable adult diabetic

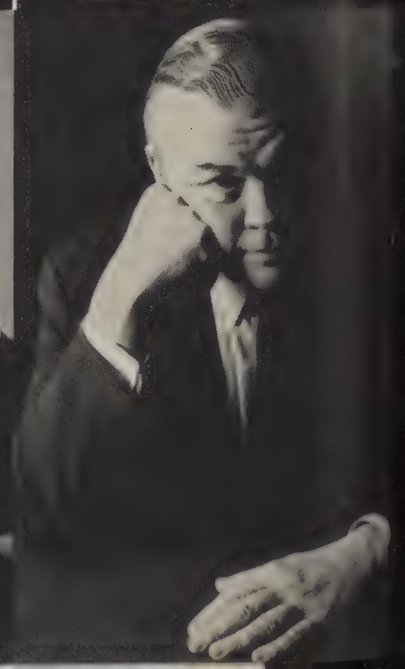
...fasting serum levels of insulin are usually normal, postprandial levels excessive[1-3]



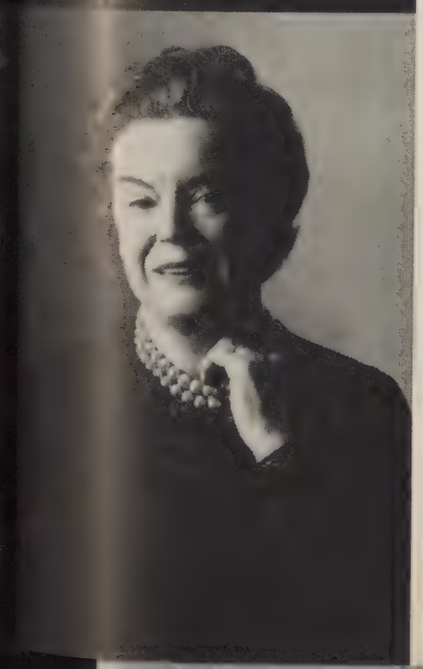
...insulin acts in adipose tissue via hexose monophosphate shunt, principal path of glucose conversion to storage fat[1,4]



...excessive endogenous insulin acts to stimulate lipogenesis and weight gain[1,3,4]



...DBI lowers high blood sugars without promoting fat synthesis, encourages gradual weight loss[2-9]



to manage the overweight stable adult diabetic unresponsive to diet alone

DBI® tablets 25 mg. DBI-TD® timed-disintegration capsules 50 mg.

BRAND OF PHENFORMIN HCl

DBI promotes glucose utilization via the physiologic Embden-Meyerhof pathway... reduces high blood sugars, lowers toward normal elevated blood insulin levels, encourages gradual weight reduction. For the ketoacidosis-prone diabetic, however, insulin is still the essential hypoglycemic agent.

side effects: Gastrointestinal, occurring more often at higher dosage levels, abate promptly upon dosage reduction or temporary withdrawal. **precautions:** Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis which is accompanied by acidosis, and treated accordingly. Lactic acidosis has been reported in non-diabetics and diabetics treated with insulin, with diet, and with DBI. Question has arisen regarding possible contribution of DBI to lactic acidosis in patients with renal impairment and azotemia and also those with severe hypotension secondary to myocardial or bowel infarction. Periodic B. U. N. determinations should be made when DBI is administered in the presence of chronic renal disease. DBI should not be used when there is significant azotemia. Any cardiovascular lesion that could result in severe or sustained hypotension, which may itself lead to development of lactic acidosis, should be considered cause for immediate discontinuation of DBI at least until normal blood pressure has been restored and is maintained without vasopressors. Should lactic acidosis occur from any cause, vigorous attempts should be made to correct circulatory collapse, tissue hypoxia, and pH. **contraindications:** Severe hepatic disease, renal disease with uremia, cardiovascular collapse. Not recommended without insulin in acute complications of diabetes (metabolic acidosis, coma, severe infections, gangrene, surgery). **pregnancy warning:** *During pregnancy, until safety is proved, use of DBI, like other oral hypoglycemic drugs, is to be avoided.* Consult product brochure for full information.

1. Gordon, E.S.: Metabolism 11:819, 1962. **2.** Grodsky, G.M. et al.: Metabolism 12:278, 1963. **3.** Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. **4.** Sadow, H.S.: Metabolism 12:333, 1963. **5.** Faludi, G.: J. Am. Med. Women's Assoc. 18:722, 1963. **6.** Faludi, G.: Geriatrics 18:452, 1963. **7.** Williams, R.H.: Textbook of Endocrinology, Ed. 3, Saunders, Phila., 1962, p. 610. **8.** Weller, C. and Linder, M.: Am. Therap. Soc., June 1963. **9.** Moss, J.M. et al.: Med. Times, July 1964.

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Darlington County Tuberculosis and Health Association

Dr. B. A. Matthews of Hartsville was elected president of the Darlington County Tuberculosis and Health Association for the coming year at the annual meeting of members.

Members of the executive committee include Drs. K. W. Krueger, Allen R. Slone, M. J. Coleman. Dr. J. S. Matthews of Darlington was elected to serve a three-year term as a board member.

21st Annual Meeting

of the
ASSOCIATION OF AMERICAN
PHYSICIANS AND SURGEONS
The Roosevelt Hotel — New Orleans, Louisiana
October 8, 9, 10, 1964

Insecticide Antidote

"Protopam chloride (PAM, Pralidoxime) is now available for the emergency treatment of toxicity due to parathion, malathion and other pesticides of the class known technically as organic phosphate esters. This has been used rather extensively in the United States and in foreign countries. The organic phosphate insecticides exert their effects by inactivating cholinesterase allowing for an accumulation of acetylcholine at the neuromuscular junction. The injection of protopam reactivates the cholinesterase which is bound to the organic phosphate ester, thus allowing the acetylcholine accumulation to be dissipated. This drug is used in conjunction with atropine."

Health Education Conference

First National Conference on Health Education Goals to be held October 30-31, 1964, at the American Medical Association Headquarters, Chicago, Illinois, and the Sheraton-Chicago.

Community Health Week

The second annual Community Health Week, sponsored by the American Medical Association, will be observed October 18-24, 1964. This has been planned to attract public attention to the medical and health facilities existing in all communities.

All communications media, particularly radio, television, and newspapers, will encourage recognition of the achievements of medicine and public health during the past few decades, as well as point up the need for local responsibility for the development of community health facilities.

Public Immunization Program Planned

A sweeping program of public immunization against communicable diseases was outlined for the Florence County Board of Health.

Dr. C. L. Murray reported that a special team from the United States Public Health Service was in Florence to begin preparations for the program which will be conducted throughout South Carolina.

South Carolina, he said, is being used for a pilot program and it is the first state selected by the USPHS.

Dr. Wentz To Begin Practice At Lockhart

Robert M. Wentz, M. D., who recently completed an internship at McLeod Infirmary, Florence, began the practice of medicine about July 6, 1964.

Dr. Wentz is a native of the state of Arkansas where he attended Arkansas Tech.

During the Fall of 1959, he moved to New Orleans, where he entered Medical School at Tulane University. After graduating there in 1963, he moved to Florence for his internship.

Dr. Pulaski Takes Hospital Residency

Dr. C. Pulaski, Hampton physician, has left his practice of general medicine in Hampton to begin a residency in surgery in Columbia Hospital, Columbia.

His plan is to return to Hampton to resume general practice. A graduate of the University of South Carolina, Dr. Pulaski received his MD at the Medical College of South Carolina in 1960, interning for one year at Columbia Hospital.

Doctor Opens Lake City Office

Dr. Asbury H. Williams has announced the opening of his office for the practice of general medicine.

Dr. Williams is a native of Lake City having been born there in 1937. He received his Bachelor of Science degree from Furman University in 1959.

He attended the Medical College of South Carolina, receiving his M. D. degree one year ago. For the past year he has served his internship at Columbia Hospital.

What Is the A. M. W. A.?

The American Medical Writers' Association—a professional society of people engaged or interested in various aspects of medical communication—will hold its 21st Annnual Meeting, September 24-27, 1964 in Philadelphia.

The A.M.W.A.'s objectives are to improve the quality and efficacy of communications within the medical world, to provide a forum and publication medium for the interchange of views among its members, and to improve the status and recognition of the medical communicator. The A.M.W.A. publishes a monthly *Bulletin,* reporting developments in this field, news of the Association's six local chapters and its 1800 members, together with original articles, book reviews and other items of interest.

Membership is available to any person "actively engaged or interested in any aspect of communication in the medical and allied professions" . . . Dues are $15 per year and the national office of the A.M.W.A. is located at 2000 P Street, N. W., Washington, D. C., 20036.

Deaths

Dr. W. V. Branford

Dr. William Victor Branford, 57, founder and chief surgeon of St. Eugene Hospital died in Dillon after a brief illness.

Dr. Branford was born in Charleston June 8, 1907. He was the first alumnus of Bishop England High School to receive an M. D. degree. Dr. Branford received his B. S. degree from the College of Charleston in 1928 and graduated from the Medical College of South Carolina in 1932.

Dr. Branford interned at Roper Hospital in Charleston. He began the private practice of medicine in Charleston in 1933.

After locating in Dillon in 1934, Dr. Branford became interested in securing a hospital for the Dillon area. With the cooperation of the Dillon Medical Society and through the efforts of the Most Reverent Emmet M. Walsh, Bishop of Charleston, St. Eugene's Hospital was constructed and opened its doors for patients late in 1943.

Dr. Branford was a member of the American Medical Association, S. C. Medical Association, International College of Surgeons, American Society of Abdominal Surgeons and the Pee Dee Medical Association. He served several terms as president of the Dillon County Medical Association.

He also belonged to the Dillon Lion's Club, Dillon Country Club and the Pee Dee Executive Club.

Dr. R. M. Hope

Dr. Hope was born March 5, 1903, in Lockhart, a son of Dr. W. D. Hope and Mrs. Mattie Hanna Hope. He was a member of Grace Protestant Episcopal Church, of which he was a vestryman.

He graduated from the University of South Carolina in the class of 1923 and worked for two years with the University Alumni Association, after which he entered the Medical College of South Carolina, graduating in 1928. After his internship, he entered practice with Dr. Josiah Smith for several years.

He was a member of the American Medical Association, the Southern Medical Association, the Charleston County Medical Society, the South Carolina Medical Association, the American Society of Ophthalmology and Otolaryngology, the South Carolina Society of Ophthalmology and Otolaryngology.

He was professor emeritus of Otolaryngology at the Medical College of South Carolina, a consultant for both the Dorchester and Berkeley County hospitals and for the Charleston City Orphans Home.

He was a member of the Carolina Yacht Club, the Kiwanis Club and the New England Society, as well as Landmark Lodge 76, AFM.

Book Reviews

LEUKEMIA. 2nd Edition. By William Dameshek and Frederick Gunz. Grune and Stratton, New York and London. 1964. 594 pages. $25.00.

In the five year period since the first edition many advances have been made in the knowledge of not only the leukemic cell but also the normal hemopoietic cell. Although not yet elucidating the etiology or producing a cure it has done much to further the understanding of the disease process and its clinical manifestations and for this reason the second edition was published.

The chromasomal changes in leukemia and its genetic implications are presented in detail. Increasing evidence of a viral etiology and the significance of "leukemic clusters" are discussed. The role of the lymphocyte, thymus and immune reactions in the so called "lymphoproliferative disorders" is brought up to date including the interrelationship of lymphosarcoma and lymphatic leukemia. In addition to the above new or revised topics the entire text has been brought up to date in an extremely complete manner.

Once again this book is most highly recommended to every physician coming into contact with patients with diseases of the hemopoietic system and as an excellent source of reference for student and physician alike.

Charlton deSaussure, M. D.

TEXTBOOK OF OTOLARYNGOLOGY, by David D. DeWeese and Wm. H. Saunders. Second Edition. C. V. Mosby Company, St. Louis, Missouri. 1964. Pp. 464. $8.75.

The second edition of this superb small volume, designed primarily for students of medicine and general practitioners, is an improvement over the first edition which was so well received. There are more illustrations of the same high quality as those which are contained in the first edition and portions of the text have been rewritten and expanded, all to its advantage. We plan to continue to use this textbook in the teaching of our students, and welcome the fact that the authors have undertaken to keep their text abreast of the times and hope that they continue to do so.

R. W. Hanckel, M. D.

MINUTES
SOUTH CAROLINA MEDICAL ASSOCIATION*
116TH ANNUAL SESSION
HOUSE OF DELEGATES
OCEAN FOREST HOTEL MYRTLE BEACH, S. C.
MAY 5-6, 1964
ROBERT WILSON, M. D., Presiding

Tuesday, May 5, 1964—1:45 P. M.

The Chair: The House of Delegates will be in order. The first order of business is the invocation which Dr. Clay Evatt will give us. (Dr. Evatt gives invocation)

The Chair: Thank you, Dr. Evatt. It is my pleasure and privilege to welcome you all to the opening of this the 116th annual session of the South Carolina Medical Association. The weather was particularly ordered for the occasion and although we had a few doubts on Saturday and Sunday of last week everything has turned out beautifully and I hope everybody has a lot of fun as well as a profitable meeting.

The Chair: The next order of business is the presentation of resolutions.

Dr. Arthur L. Rivers: Mr. President, delegates, I make the following resolution for consideration:

"That there be established a Standing Committee of the South Carolina Medical Association for review of professional and economic policies and practices of hospitals and of state institutions and agencies whose work deals with the practice of medicine, with regard to their being in the best interest of medical care; the Committee to consist of five members appointed by Council in such a manner that one member retires each year. No member may serve more than two consecutive terms.

The Chair: This resolution is referred to the Committee on Miscellaneous Business.

Dr. Robert S. Solomon: Mr. President and delegates, this is a resolution from the Emergency Medical Care Committee to be presented at the discretion of the South Carolina Medical Association to the South Carolina Board of Health.

The resolution:

Whereas, the Committee on Emergency Medical Care, South Carolina Medical Association, realizes that total emergency preparedness is based on individual and group self-sufficiency and that the people of South Carolina must be trained in the fundamental emergency medical techniques which may save their lives following a nuclear disaster or natural disasters, such as hurricanes, transportation accidents and others;

Whereas, Medical Self-Help Training combined with the American Red Cross Basic First Aid course is a program designed to provide information and training to the people of South Carolina that will help prepare them for survival in the time of national disaster when the services of physician or other allied health person are not available;

Whereas, the initial goal is to train at least one member of each family in Medical Self-Help combined with the American Red Cross Basic First Aid Course;

Whereas, it is realized that without the help and assistance of school training, particularly from the 9th grade upwards, our state goals cannot be achieved;

Be It Resolved, That the South Carolina Medical Association recommends to the State Board of Health that a combined Medical Self-Help-American Red Cross Basic First Aid Training program be instigated in all of the public schools of South Carolina and that school officials be enjoined to include periods in the school curriculum in Medical Self-Help-American Red Cross training, beginning with the 9th grade level students;

Be It Further Resolved, That the Committee on Emergency Medical Care, South Carolina Medical Association, realizes that Medical Self-Help-American Red Cross Basic First Aid training is a continuing program and that this program is one of the disciplines that the citizens of South Carolina will have to live with. Therefore, the Committee strongly encourages continued emphasis on and support of this vital and worthwhile program."

I would like to state that in addition to this resolution, which has been unanimously approved by the Emergency Self-Help program, that this program has already been initiated in Berkeley County with the cooperation of the physical education teachers and some home economic demonstration teachers and it has been a very successful program since it has been initiated. If we are going to get at least one or more members of each family to participate in the Medical Self-Help, which to our manner of thinking, combined with the Basic Red Cross Program, this should be initiated at every school and be a part of the curriculum and can be worked in conjunction with the physical education programs, etc., of the various school curriculum. I feel that this House of Delegates should ask that the State Board of Health have each County Supervisor of Education initiate this program in every county of South Carolina. It has been working in my particular county for the past three months. The Red Cross is interested in participating and I think it will be a tremendous program for the entire educational system.

The Chair: This resolution is referred to the Reference Committee on Legislation and Public Relations.

Dr. George G. Durst: Mr. President and Delegates, I have a report from the Mental Health Committee. Dr. Galloway, who is Chairman of the Committee, is away in San Francisco attending another meeting. The recommendations of that committee have been published in the April Issue of the *Journal*. I will not read the full report unless requested.

The Chair: No, that is not in order this morning.

Dr. Durst: The recommendations are:

1. "That members of the Medical Association be reminded of the 1963 report of this committee.
2. "That intensive study be made by all physicians and County Medical Societies of the reports of the Governor's Advisory Group on Mental Health Planning. Specific response and recommendations are imperative.

*This is an edited version of the minutes in which some of the routine parliamentary procedures and customary amenities have been omitted for lack of space. The verbatim copy of the proceedings is in the hands of the Secretary.

3. (This is the part that the Committee feels is especially important)
"That physicians and County Medical Societies actively participate in the development of Community Mental Health Centers with particular attention towards inclusion into existing general medical facilities."
(The Committee is concerned and feels that all of this society is concerned in seeing that these do not become cloistered clinics and out of the mainstream of our medical facilities.)
4. "That the Council and House of Delegates consider ways and means to support, assist and augment the work of the South Carolina Mental Health Commission."

The Chair: This report is referred to the Reference Committee on Public & Industrial Health.

Dr. Swift Black: Mr. President and Delegates, on behalf of the South Carolina Chapter of the American Academy of General Practice I would like to present the following for your serious consideration. It comes as a result of action taken by the American Medical Association in its endeavor to better meet the medical needs of the general population. As you know, more and more recent graduates from medical schools of the country enter into some field of research or specialty, rather than into general practice. This has resulted in a shortage of family physicians. Although 75% or 80% of the general population see a family physician first with their illness only about 20% of the graduates enter general practice.

"Last June, in Atlantic City, the AMA House of Delegates passed Resolution No. 68 calling for additional emphasis on the training of general practitioners."

And with this in mind I would like to present the following resolution:

"*Whereas,* The American Medical Association in session assembled took additional recognition of the "importance of the general practitioner as an essential component of American Medicine," and
Whereas, once again recognition was taken of the need for "an adequate number of medical school graduates selecting general practice for their medical careers," and
Whereas, the AMA did resolve to "instruct its Board of Trustees to utilize all facilities at its command to:
a) inform the medical schools of the shortage of practitioners, and request their cooperation in exposing medical students to general practice by lectures, preceptor programs, and clinical instructors who are practicing general practitioners, and
b) inform the constituent state medical associations of the need to emphasize general practice training and to ask these associations' members to encourage students to go into general practice," now therefore be it
Resolved, That the South Carolina Medical Association House of Delegates likewise take cognizance of this problem and instruct our Council to utilize all facilities at its command with deliberate speed to implement the intent of Resolution 68 passed by the AMA House of Delegates, and further be it
Resolved, That the SCMA Council report back to the 1965 House of Delegates what actions have been taken in the State of South Carolina and what progress has been made in solution of this serious problem facing the American public, namely, the impending critical shortage of general practitioners to serve the public."

The Chair: This resolution is referred to the Reference Committee on Miscellaneous Business.

Dr. William Weston: Another resolution, Mr. President.

"Since the U. S. Public Health Service has indicted tobacco as a cause of respiratory cancer in the human being of those who use tobacco, we, the Members of the South Carolina Medical Association, request that a Committee be appointed by the Governor of the Sovereign State of South Carolina to look into and investigate the other causes of respiratory cancer."

The Chair: That resolution is referred to the Committee on Public and Industrial Health.

Dr. James A. Hayne: Hampton County Medical Society has instructed me as their delegate to present the following Resolution:

"*Whereas,* The South Carolina Medical Association and the American Medical Association oppose Medical Care of the Aged financed under Social Security, and feel that the need, where it exists, can be met under the provisions of the Kerr-Mills Law, and
Whereas, The Kerr-Mills Law is being utilized in South Carolina and meets the needs of the needy, but fails to meet the needs of the near-needy, Therefore
Be It Resolved, That the South Carolina Medical Association study the possibilities and advisabilities of recommending to the State Legislature that Kerr-Mills be broadened so that the needs of the near-needy, and those who meet with catastrophic disease can be met.
It is suggested that a deductible clause be included as part of this coverage for those who earn in excess of the present income limitations."

The Chair: This resolution to the Reference Committee on Legislation and Public Relations.

Dr. Tom Parker: Mr. President and Delegates, this is a resolution of the Greenville County Medical Society and it deals with compulsory area-wide planning for health service. As you know there is currently a program which is being pushed by the Federal Government, by labor and by Blue Cross and by the American Hospital Association to set up committees, area-wide, state and national, which will control the construction of all new hospital beds, the maintenance of existing hospital beds and the utilization of these beds. Obviously the next step is who is going to use them.

With that background, this is the resolution:

Resolution on "Area-Wide Planning for Hospitals"

1. *Whereas,* the United States Public Health Service in collaboration with the American Hospital Association, has conducted a survey and issued a joint report on "Area-Wide Planning for Hospitals," and
2. *Whereas,* this report, as well as burgeoning literature on the subject, presents the thesis that only the big voluntary non-profit or government hospital can render complete or the best medical service, and
3. *Whereas,* these reports, referred to, further advance the seductive argument that the building of private-for-profit hospitals may deprive a *community* of an "opportunity" to obtain government funds for a non-profit institution, and
4. *Whereas,* these reports encourage compulsory area-wide planning for hospitals and other health facilities to be implemented by legalized state agencies, and
5. *Whereas,* the President of Blue Cross, Mr. Walter J. McNerney, has been quoted as stating "any group which builds without reference to community planning jeopardizes the solvency of Blue Cross," and

6. *Whereas,* in one area their Blue Cross tried to deny claims from a hospital which had expanded its plant without consulting its area planning board, and
7. *Whereas,* federal money is now being used for state-wide surveys for area-wide planning for health facilities in Minnesota, Kansas and and Hawaii, and
8. *Whereas,* efforts are being made in various states to establish compulsory area-wide health facilities planning on a statutory basis, and
9. *Whereas,* S.855 by Senator Hubert Humphrey, which passed the Senate last month without debate, affords federal recognition and commendation to all such planning boards and commissions and lays the groundwork for ultimate complete control by such boards, and
10. *Whereas,* compulsory area-wide planning for health facilities is dangerous, unnecessary, and inconsistent with the time-proven success of free enterprise to solve such problems; therefore, be it

Resolved, that the House of Delegates of the South Carolina Medical Association in regular session assembled, this 6th day of May, 1964, opposes compulsory area-wide planning for health facilities and calls on its delegates to the House of Delegates of the American Medical Association to present this resolution to the House of Delegates of the American Medical Association in San Francisco in June 1964 with the request that the American Medical Association take similar action; and be it further *Resolved,* that the Legislative Affairs Committee of this Association be instructed to alert the governing boards of the several hospitals of this state to the dangers inherent in such compulsory planning."

The Chair: This resolution is referred to the Reference Committee on Public and Industrial Health.

For the next order of business I will ask Dr. A. C. Bozard, Vice-President, to take the Chair while I give my report.

Dr. A. C. Bozard: The next order of business is the Report of the President, Dr. Robert Wilson.

Dr. Robert Wilson: "Mr. President, one of the happy privileges in my professional life has been the opportunity to serve for the past year as President of the South Carolina Medical Association. I am deeply grateful to the House of Delegates for according me this distinction, and I thank you all for your confidence in choosing me for this office. During the past year the work of the Association has gone on, but the real achievements of our organization are due to the tireless efforts of the Council, of the various committees, as well as to the devoted work of the Executive Secretary, and to each and all of these I am pleased to give the very special thanks of the Association.

The past year has seen some disappointments as well as accomplishments in the work of the Association. Our advice as a constituent of the State Board of Health went unheeded, and the Legislature last year enacted a bill, approved by the Governor, allowing a former naturopath to practice as an "eclectic physician." However, another similar bill introduced into the recent session of the Legislature was met with formal opposition on the part of the Association and was defeated. Likewise, our representatives appeared before a joint committee of the Legislature opposing a proposal to enlarge the scope of the practice of osteopathy and in this we were again successful.

I believe that the Association could well stress its role as a constitutional constituent of the State Board of Health. In this capacity we are charged with the responsibility of advising public officials in all matters pertaining to the health and welfare of the people of South Carolina. This gives us the opportunity to speak with authority, in a way in which we must be heard and from a platform designated by the State; when our advice given in this manner goes unheeded, those who disregard it will immediately be put on the defensive and must explain their actions taken in opposition to their constitutional advisors.

A noteworthy event of the past few months has been the publication by Dr. Joseph I. Waring, Editor of the *Journal* and Chairman of the Committee on Historical Medicine, of his book entitled "A History of Medicine in South Carolina, 1670-1825." This scholarly work, representing as it does endless hours of painstaking historical research and careful selection of facts from the past, is indeed an accomplishment of great magnitude and one to which every physician in the State can point with great pride.

On the work of the many committees of the Association depends the success or failure of our programs; to all of these I am deeply grateful. However, I would like to call your attention to the reports of certain of these committees for some action at this time. At the last annual meeting it was pointed out that there were a substantial number of physicians practicing in the state who were not members of the South Carolina Medical Association. An ad hoc committee on Membership under the co-chairmanship of Dr. W. V. Branford and Dr. R. S. Clarke, Jr. was appointed to study the reasons why this is so. This committee has reported its findings in the April issue of the *Journal;* perhaps the House of Delegates should consider some type of associate membership or other means whereby at least a number of these physicians could be brought into the Association; certainly this committee should be continued and I would specifically recommend that this be done.

This year has also seen the beginning of a very worthwhile project in Public Relations in the work of another ad hoc committee on Public Health Information. Under the Chairmanship of Dr. Louis Jervey of Charleston, this committee has prepared a number of press releases on a wide variety of topics of public interest which have been published in several newspapers over the State. It is especially true that when sound medical knowledge can be tied in with some local newsworthy event, the press is most anxious to have this type of story immediately available. An exhibit of some of these articles is on display in the lobby. I would call your attention to this exhibit and to the report of this committee and I would strongly recommend that it be made a permanent committee of the Association.

Last year the House of Delegates authorized the establishment of a permanent committee on Post-Graduate Education. The sponsoring of opportunities for continuing medical education, the encouraging of physicians to participate in these activities, and the development of all facets of scientific work should be the most important activity of the Association. The report of this committee, under the Chairmanship of Dr. William Klauber, points out some of the ways in which this is now being explored. Every encouragement should be given to the work of this committee, and perhaps correlation with the Scientific Program at the annual session might be better effected by the inclusion of the Chairman of the Program Committee as an ex-officio member of the Committee on Post-Graduate Education. This I would recommend.

The activities of the Committee on Accident Prevention should have the wholehearted backing of the Association. The enactment into law of some of the suggestions to promote highway safety should be one of our prime objectives. During the past year, it was

suggested to both the Committee on Legislation and the Committee on Accident Prevention that the Association propose legislation requiring that all prescriptions containing toxic substances be labeled with their generic name by the dispensing pharmacist. This might well prove to be a time saving factor in cases of poisoning; while there might be certain difficulties in securing the passage of such legislation, I would recommend that the Association endorse this in principle and ask for the cooperation of the Pharmaceutical Society in securing its eventual passage.

A special committee of Council has been at work considering a possible location for a permanent headquarters for the Association. While we are not now in a position to go through with plans for the construction of such a headquarters building at this time, certainly some thought should be given as to its eventual location and the investment of some of the building funds of the Association in real estate should be considered by Council when a suitable opportunity is offered.

In facing the problems of the future it is my sincere hope that the Association, and all its members, will continue to follow an attitude of militant progressive conservatism. In our civilization of today, change is inevitable. Our leadership must constantly strive to mold and to guide public opinion into paths that are fair, reasonable, and to the best interests of all of our fellow citizens and not only of ourselves. Often these paths will coincide. To accomplish these aims, in our political complex of today, we must direct our efforts toward the influencing of public officials, we must utilize organizations such as SCALPEL, we must ourselves be active in public affairs and be militant in presenting our views. Only in this way can we hope to reach our goal." Thank you very much.

(Dr. Wilson resumed the Chair.)

The Chair: It is not quite time for the introduction of the guests and officers of the Woman's Auxiliary, so it is my great pleasure to present to the South Carolina Medical Association our President-Elect, Dr. Frank Owens, who will address the Association.

Dr. Frank C. Owens: Mr. President and Members of the House of Delegates. There are approximately 1500 members of the South Carolina Medical Association in this state. You are their representatives. You are the leaders of our profession in this state and in your hands rests the future of medicine in South Carolina. Our state ranks low in the number of doctors per capita but we rank high in the standard of medical care furnished to those who seek the services of the South Carolina doctor.

The dictionary defines a profession as an open declaration or avowal; a calling; it goes on to state the learned professions are theology, law and medicine. It defines a trade as a carrying on of a business of bartering or buying or selling. It defines business as the buying or selling of goods; a commercial or industrial enterprise of any kind. Ours is a profession —a calling. If we have entered the practice of medicine with the conception that it is a business from which we might amass a fortune then we are in the wrong place. Ours is a calling of service. Our mission is to prevent illness, heal the sick and relieve the suffering. The commercial aspect should be secondary. It is true, that if we apply ourselves to our profession that the monetary rewards will naturally fall in place, yet we must not lose sight of the fact that ours is a mission of healing and not of monetary gain. There breathes no doctor or there should breathe no doctor who does not get a far greater satisfaction from a favorable response of a pneumonic ill patient or one with septicemia than with the acquisition of the check that pays the bill. The most joyous sound



Dr. Swift Black, New Vice-President, Dr. Julian Price, President-Elect, Dr. Robert Wilson, Retiring President, Dr. Ben Miller, Secretary, and Dr. Frank Owens, President.

I have ever heard is the cry of a new born baby—particularly when the delivery was difficult. It far outranks the tinkle of the silver that drops in the till. The privilege extended to the incoming president of the Association to express some of his thoughts prior to assuming office is an appreciated one. From the past we gain experience but it is the future that holds the challenge and it is in the future that new problems must be met. There is no one man accomplishment in the South Carolina Medical Association—it is a cooperative effort. Each of you and each of the members of the Association is an integral part of our overall program and your efforts are necessary for successful accomplishment. I ask your help and your advice.

The chief challenge today is the threat to the very foundations of our free enterprise practice of medicine, the system of medicine that has made this country the medical leader of the world. Instead of sending our men to England or Germany as once was the practice, we now receive those from England and Germany and elsewhere into our medical centers so that they might learn the latest techniques and the best in medicine. It is no accident that the life span in the last fifty years has been increased from 50 to 72 years. It is under our system that this was accomplished. If continued progress is to be made in lengthening life and shortening the duration of disease, then the present system must be preserved. While it is obvious to us that this is necessary—the general public is not so well informed on the dangers. It is incumbent on us that they are informed. Our AMPAC and our own SCALPEL are two avenues through which this can be accomplished. An all out effort must be made to defeat the King-Anderson Bill and all of its socialized medicare medicine relatives.

During the past year—and in other years for that matter, I have been deeply concerned by the dearth of doctors in this state except in a few concentrated areas. Particularly is this true in the General Practitioner category. As chairman of the Medical Advisory Committee to Selective Service it has been my unpleasant duty to render an "Available for Service" opinion on a number of doctors just finishing their internship. While there is no "convenient" time for a doctor to enter service, at the same time it has been determined by National S. S. Headquarters that the least inconvenient time is immediately upon completion of their internship and before they enter

a residency or private practice. This, I think, was a wise determination. However, it has brought forcibly to my attention the problem the smaller communities have in securing a doctor. I feel that the training of doctors for war emergency is a paramount procedure. While we have been furnishing some help to inquiring areas about doctors who might be available, still I feel that more help should be given. This problem ties in with the dropping off of the number of men who go into General Practice. I would like to recommend that a committee be appointed to be known as the Doctor Procurement Committee whose function it shall be to aid communities in securing needed doctors.

And speaking of the armed forces, I would like to call your attention to the plight of the organized reserve in this state. Enlistment in the reserves immediately removes one from the Selective Service jurisdiction. The obligation is for six years, you build up credit and there is a two weeks camp each year. Drills are usually twice a month and you can commute to those. The chances of your continuing your practice is good unless there is a national emergency and then you would be called anyhow. There are organized Reserve Units in this State in Greenville, Charleston, and Columbia—and a Medical Dispensary in Florence. Of a total authorized strength in South Carolina Units of 55 doctors there is a shortage of 44 doctors. For instance, Florence is authorized two doctors and they have none. Charleston is authorized 12 and they have 2. Greenville is authorized 12 and they have 3, and Columbia is authorized 29 and they have 6.

None of us relishes the contemplation of the chaos of war. But history proves that it occurs with inevitable irregularity. There is an old saying that "—the pen is mightier than the sword—" but let us realize that the strongest military might dictates what the pen shall write. The Reserve program is one of the elements of the necessary defense of our Country. It can help to prepare you to render better service to your Country.

The reports of the various committees form the basis of an excellent program for the coming year.

The problem of medical care for the aged is being largely met by private insurance companies and by Blue Cross-Blue-Shield; but there are certain areas in which it appears the government has some responsibility. This responsibility is being met by the Kerr-Mills Act. During the past year this has been utilized in this state to the following extent. The South Carolina Department of Public Welfare, which administers the provisions of the Kerr-Mills Act, operates on a fiscal year—from July to July. During the last fiscal year bills were paid for 5,670 hospital cases, which represented 66,578 hospital days. There was paid to the hospitals—$1,330,546.37. In addition to this there were 489 nursing home cases representing 12,580 days for which the nursing homes were paid—$50,138.33. There were 3,407 out patient cases. In all there were 9,566 bills paid. There were 79,158 days used and the total expenditure for medical assistance was $1,409,293.20. The State of South Carolina paid 20% of this and the Federal Government 80% or the State paid $281,854.64 and the Federal government $1,127,438.56. There are now on the eligible list for Kerr-Mills benefits 12,000 and there are many who are eligible who have not established their eligibility. The number increases yearly. We have all seen the benefit which this help accomplishes; and from the AMA on down, it is approved. We all have also seen that there are areas which are not reached by the Kerr-Mills Act, that perhaps, should be covered. Further implementation of this act might be advisable. We have a committee on liaison with the South Carolina Department of Public Welfare and perhaps that committee should study the possible extension of the Kerr-Mills implementation. If we are to successfully combat the threat of government socialized medicine, we must not only present the picture as to what is wrong with socialized medicine but present a positive picture as to what is being done and can be done in a positive manner to relieve the problems presented.

The Accident Prevention Committee of the South Carolina Medical Association has recommended—and there are national programs for the administration of tetanus toxoid to as large a percentage of our population as possible. There is not a Doctor who does not experience a certain amount of trepidation when he learns that the trauma victim has had no tetanus toxoid immunization. He and, to a large extent, the public realize the dangers of tetanus antitoxin reaction—from the itching and welts, all the way to death. But what the public does not realize is the danger of NOT having proper immunization. Tetanus causes 50,000 deaths a year and many of these, a large percentage of these, occur in persons who are not given proper immunization. The administration of tetanus toxoid because it is an injection procedure, does not lend itself to a statewide program as did the administration of the polio vaccine. However, I think we should make a special effort to have all school children receive the injections and promote a project to bring about prophylactic tetanus toxoid immunization in all industrial workers, and as large a percentage of our population as possible. A committee report will outline the procedures that can accomplish this.

Our medical college has recently undergone a rigid inspection and the inspectors were very pleased with what they found. We are all proud of our medical college and the work it does. We should give our full support to its development. With the changing world and the advance of science, today's graduate might be confronted tomorrow with a new medicine or a new procedure—if it is new to the new graduate think what it is to the old grad. The program of continuing medical education is a most important link in medical care. Medical ETV is most valuable and symposiums held by the medical faculty over the state render valuable service. Continuance and expansion should be our attitude to these important links.

Nursing care continues to be a problem in the overall medical attention set up. Not only is there an apparent shortage of trained nurses for ill patients but there is difficulty in getting nurse attention in the hospitals. The increased utilization of practical nurses is evidence of these facts.

Our association has had a committee working on this problem and they have done excellent work in pinpointing the difficulties encountered and in pointing the ways to solution. Continued activity of such committee is a necessity.

The individual doctor is held in high esteem by his patients but the TV and comedian jokes on doctors' bills and their failure to tell the patient what is wrong with them brings instant applause and bursts of laughter from their audience. While the doctor and the medical profession is as deserving of prestige as ever before—yet the public has been fed a diet that the doctor is a selfish commercialist. This image is not according to facts. One or two five dollar visits and three dollars worth of an antibiotic can save one or two hundred dollars in illness. One or two laboratory tests can often point to a life-saving diagnosis, a life is worth more than a few dollars. Where is the costly mastoid operation and hospitalization—gone thanks to medical progress and a few pills. The

cost of medical treatment has been put in big headlines—the beneficial effects in small type on the back page. A special effort should be made by us to see that the public has a proper picture of the service rendered and the accomplishments of that service.

Now, gentleman—and ladies—I am proud to be a member of the medical profession. The M.D. that we sign after our names should be written with a flourish and with firmness. As we go through life in our chosen profession, remember that to us are given talents and knowledge not accorded to all men. Let us remember to use them for the betterment of the sick and ill of mind and in accordance with our patron saint, Hippocrates, who said "I will follow the system and regimen, which, according to my ability and judgment I consider for the benefit of my patients."

In any basic decisions that we make, let it be with a vision as to what is best for the patient in accomplishing our mission in the art of healing. Thank you. (Applause)

The Chair: Thank you, Frank. That will be referred to the Committee on Reports of Council & Officers. I would like to appoint Dr. Martin Teague and Dr. A. C. Bozard to escort the officers of the Woman's Auxiliary to the rostrum at this time. I think they are waiting outside. (Ladies are escorted in and the House of Delegates rises and applauds.)

Mrs. Baker and Mrs. Burns, we are delighted to have you with us as our guests and we would appreciate a word from you. Elizabeth.

Mrs. Ralph Parr Baker, President: Thank you, Dr. Wilson, members of the House of Delegates to the South Carolina Medical Association, I am happy to be here.

"In the poem, "A Tuft of Flowers," Robert Frost expresses the idea:

"Men work together, I said within my heart,
'Whether they work together or apart' ".

This is true of our 16 auxiliaries composed of 967 members scattered as we are throughout 28 counties in the state, but working for a common goal—to serve and communicate in the best interest of medicine.

I am delighted to have this opportunity to mention a few of our outstanding activities and accomplishments. A complete report is printed in the Auxiliary Convention program.

Our efforts in Health Careers have been most successful in introducing to young people the challenging opportunities in medicine, nursing, and the allied fields of medicine. More than 1300 high school boys and girls are members of 38 Health Careers Clubs in the state. Three auxiliaries are now sponsoring the Candy Striper programs in their local hospitals with approximately 350 girls and boys actively participating.

Mental Health programs were carried out in each auxiliary. Suicide prevention was stressed this year. There has been a tremendous response to International Health Activities. This committee is only 2 years old nationally. Six counties have collected and shipped 48 cartons, approximately 1200 pounds, of sample drugs, used medical equipment and medical books, and 5½ drums valued at $16,500.00 of drugs and medical supplies to mission hospitals and clinics in remote areas of the free world.

Safety projects have included poison control, water safety, use of seat belts, GEMS (a baby-sitter training course), the Sabin oral vaccine program, tetanus immunization, and the new program for the year on gun safety in the home.

In legislation, auxiliaries were asked to assist the local medical societies in promoting "Operation Hometown." Physicians' wives were urged to join SCALPEL.

Money raised for AMA-ERF amounted to $3,675.41, an increase over the past year. Greenville County again contributed the largest amount, $2,292.00, derived from their "Give-Up-To-Give-To-Medical-Education" Christmas Card Project.

The new AMA program on medicine and religion was one of the most rewarding in inspiration, and information. This certainly presents a challenge for further investigation.

Our deep concern for the needs of American Medicine has been shown by the high quality of our projects, the sincerity of our purposes, our realization of individual responsibility, and the pursuit of our goal of service and communication.

My sincere thanks to your president, Dr. Wilson; to the Chairman of our Advisory Committee, Dr. Nachman, and his committee; to Dr. Burnside, Chairman of Council, and the members of Council; to Dr. Waring, Mr. Meadors, and others for encouragement, direction and guidance." Thank you. (Applause)

The Chair: Thank you, very much, Mrs. Baker. During the ten years I served as secretary of the association I found out that the most important committee of all, to be notified immediately, was the Consulting Committee to the Woman's Auxiliary and that was the first thing I did when I took over last year. It has been a great pleasure to serve with you and I achieved something this year that I never achieved before, that is, I became a "cover girl" on the cover of the "Recorder" for last January when I spoke to the Columbia Society alongside of Elizabeth Baker.

The President-Elect of the Woman's Auxiliary, Mrs. Burns.

Mrs. C. B. Burns, President-Elect: Dr. Wilson, Members of the House of Delegates, as President-Elect of the Woman's Auxiliary to the South Carolina Medical Association, I have spent much time this year observing and learning which has made me cognizant of my duties and responsibilities.

The privilege of attending as a delegate the Woman's Auxiliary to the American Medical Association Convention in Atlantic City, June 16 to 20, 1963 was a most helpful and an enlightening experience.

The Fall Executive Board Meeting in Newberry on September 18, 1963, which I attended, was indeed informative and interesting.

I attended the Annual Fall Conference of State Presidents and Presidents-Elect which was held at the Drake Hotel in Chicago, October 6 to 9, 1963. One of the duties of the President-Elect was to prepare a detailed report of this Conference which was published in the November issue of the *Auxiliary News*. This Conference was a rewarding opportunity to glean the aims, work and plans of the Auxiliary. The capable and enthusiastic leaders had prepared and completed a most informative program.

I attended the Health Career Rally held at the Wade Hampton Hotel, Columbia on March 13, 1964.

State Board members for 1964-65 have been secured. Letters were sent to outgoing, as well as incoming, Board Members concerning the Post-Convention Board meeting on May 7, 1964 at Myrtle Beach, South Carolina.

The Round Table Conference for County Presidents and Presidents-Elect has been arranged. Letters were sent to all retiring County Presidents and to the new Presidents asking them to attend this meeting on May 6, 1964 at Myrtle Beach, South Carolina.

It has been most helpful during the past months to be associated wth our President, Mrs. Baker. My sincerest thanks and deepest appreciation to her for her help and guidance. Thank you.

The Chair: It has been a great pleasure to have you both with us this afternoon and we hope we will see a lot of you during the next few days during the meeting. (The ladies are escorted out while the convention stands.)

Some of the members of the Reference Committees are not here and I will at this time ask a number of you to serve on these committees. Dr. Keitt Smith, and Dr. S. P. Fleming—are they here? On the Credentials Committee I will ask Martin Teague and Dr. J. F. McLaughlin to serve on the Credentials Committee. All members are present on the Reference Committee on Reports of Council and Officers.

The Legislation Committee, Dr. J. S. Garrison is absent, I understand, unless he has just come in. Dr. Strother Pope, would you serve on that committee.

(It was learned that Dr. Pope was present but was on one of the other committees.) How about Dr. C. R. May. (Dr. May stated he was on the Reference Committee on Amendments of Constitution and By-Laws.) Well, give me a minute and I will fix that up. On the committee on Public and Industrial Health—Dr. Poda, Dr. Watson and Dr. R. M. Anderson are absent. I will ask Dr. Fred Nigels, Dr. Arthur Rivers and Dr. E. W. Taylor, Jr., to serve on that committee.

On the Committee on Amendments to the Constitution and By-Laws I will ask Dr. W. W. King to serve on that committee in the place of Dr. T. C. Furman. The Committee on Insurance, Blue Shield-Blue Cross —Dr. E. O. Hentz is absent. Would you be so kind as to serve on that committee, Dr. Solomon. All members are present on the Miscellaneous Business Committee. Dr. F. R. Huff is absent from the Sergeant-at-Arms and Tellers. I will ask Dr. Kenneth Lynch, Jr. to serve on that committee, Dr. J. A. Hayne is Chairman.

The next order of business will be the report of the Executive Secretary, Mr. Meadors.

Mr. M. L. Meadors: Dr. Wilson and gentlemen, before reading my report I would like to announce the places of meeting of the Reference Committees. These will be on the blackboard at the back of the building as you go out.

Report of the Executive Secretary

Mr. Meadors: The past year has been a busy one for the Executive Office. One of our staff remarked a few days ago, that after the Annual Meeting last year, there was not much evidence of the usual lull in activity which ordinarily occurs about that time of year. The principal reason, of course, is the normal increase of work as a result of the widened scope of the activities of the Association over the past several years. The increase in membership, combined with the multiplied additional activities of AMA with which it is necessary for us to keep in close contact are the factors responsible.

The activities of the office may be divided into three broad classifications: (1) Business Administration, (2) Liaison, and (3) Legislative.

Business Administration. Statistically, the Association continues to make steady progress. The number of members in good standing for 1963 was 1512, as compared to 1472 at the end of the previous year. Of the total, 1361 paid the regular dues of $35.00 each, 15 paid half-year dues of $17.50, having joined the Association after July 1st, 3 were Junior members, paying $3.00 per year, and there were 11 members in military service and 122 Honorary members, both of which categories are exempt from the payment of dues. Income from the dues collected, including the $3.00 allocated as subscription to the *Journal*, amount to $41,468.00, plus $6,082.50 for the Permanent Home Fund.

The business administration of the *Journal* is handled through this office, and income from advertising last year, amounted to $23,284.00.

In addition, the sum of $5,740.00 was realized from interest and dividends, and all of this amount was re-invested. All of the revenue, however, was insufficient to cover the expenses and investments and the Association again operated at a deficit.

The annual meeting, through last year at any rate, continued to pay its own way. The sale of exhibit space to our commercial exhibitors resulted in sufficient income to pay the expenses of the meeting, but with little profit.

In addition to our own revenue, we collected for and remitted to the American Medical Association, $58,-300.00, representing the dues of 1255 members of that organization. Although, of course, there are more members of the State Association than of AMA, the amount is much larger by reason of the fact that the dues of the national organization are $10.00 higher per year than our own. We have also handled and remitted through our office, $6,215.00 in contributions to the American Medical Education and Research Foundation, most of this at the rate of $10.00 per member from those of our members who contributed voluntarily. Altogether, therefore, we collected and disbursed through our office, a total of $143,500.00 during the year.

Of course, the records on all this must be, and are scrupulously kept by the members of our staff.

Liaison. A part of our duty, and a great deal of the work involved, consists in providing the necessary liaison between county and district medical societies, with each other and with the State organization, the answering of inquiries, furnishing information to the members generally concerning the Association's work, its insurance programs, special committee projects, etc. This entails a great deal of correspondence, and the maintenance of records and information on the membership and officials of the societies and the activities of the Association in general.

On February 16th, a County Society Officers Conference was held in Columbia, the program for which was arranged by our office working in conjunction with Dr. Waring, Chairman of the Committee on Public Relations. The meeting was very well attended, and it was devoted principally to administrative affairs of the Association, our insurance programs and discussion of the King-Anderson Bill. Mr. Aubrey Gates, Chief of the Department of Field Service of AMA was the guest speaker. We would like to take the opportunity to express our thanks to those county society officers who were present and who have followed our suggestions with respect to the remittance and listing of membership dues. The forms provided and suggestions made at that Conference were followed by a number of the Secretaries of the larger counties, and have helped a great deal in our handling of the records within the past few months when time has been at a premium.

This phase of our activity includes, also, coordination of programs and liaison with other state associations, and with the AMA. This has increased materially. There is scarcely a time during the year when one or another of the departments or commissions of the American Medical Association is not planning or conducting a national or regional meeting with reference to some phase of its interests in behalf of the profession or the public. Many of these, it is necessary for us to attend, and we continued to do so in 1963 as in the past, among them being, the annual and interim meetings of the House of Delegates of AMA, Medico-Legal Conference, the Public Relations Institute, Legislative Conference and the Conference on Mental Health. There were a number of others. While these require a good bit of time out of

the office and trips out of the State, this is recognized as necessary in order to keep your Association informed, abreast of, and participating in the activities of the profession nationally.

Legislative. The third broad phase of our work has to do with the Association's interest in legislation, both state and national. This year legislative activity was required concerning more bills than in any other single year in our experience. And our success, or good fortune continued. Beginning early in February, and continuing until within two weeks of the end of the legislative session, there were bills pending with which it was necessary for us to be concerned. We are pleased to be able to report that nothing was passed which you opposed, that one bill was passed in a form recommended by the Association, but without the necessity of our active participation, and in another instance, recommended changes were made in pending bills and final passage accomplished in accordance with the views and recommendations of your organization.

To begin with, a bill to license a second former naturopath as a Doctor of Eclectic Medicine, as had been done the previous year with respect to Representative C. A. Mitchell, of Oconee County, was strongly opposed and killed in committee. The Mitchell Bill, incidentally, was up for final action the day this meeting adjourned last year. Although it was never approved, it was not contested in its final form and the licensing of Dr. Mitchell, while undoubtedly a poor form of legislation, has resulted in no cataclysmic consequences. Actually, the fact that the South Carolina Medical Association did not undertake to press the issue finally as to their disposition with respect to a harmless member of their own body seems to have been appreciated by the lawmakers.

Last Fall, the podiatrists of the State requested cooperation in revising the law governing them and in extending the privileges of their licenses. A committee was appointed by Council at the October meeting to meet with representatives of the podiatrists, and this was done a short time later. Subsequently, the Association's committee concluded that the additional privileges desired by the podiatrists were not warranted by their training and qualifications, and they were so notified.

About the middle of the legislative session, however, the podiatrists had a bill introduced in the Senate to carry out their wishes. This was referred to the Committee on Medical Affairs, from which it never emerged.

The bill which caused us most concern was that with respect to the osteopaths. It will be recalled that this group has made repeated efforts to broaden the terms of their license to include virtually all the privileges of a doctor of medicine. Every two years, a new bill is introduced. The one proposed in 1963 was referred to the Senate Committee on Medical Affairs and remained there throughout the Session. We had requested a public hearing before action was taken, and this year, the hearing was held. Your Association was represented by the president, the president-elect, the chairman and two other members of Council, and the executive secretary. Our case was strongly presented against what appeared to us to be a very poor showing for the osteopaths. Nevertheless, some weeks later the bill was reported out of committee but without recommendation. We promptly contacted members of the Association in every county, the doctors responded splendidly, and it soon became obvious that the bill had no chance to pass the Senate. When it was finally reached on the calendar, a motion to recommit was passed by an overwhelming aye-no vote, and this, of course, meant its death. The osteopaths will probably be back again next session, and the next.

At the direction of the House of Delegates last year, we assisted the Committee on Legislation in preparation of a so-called "Good Samaritan" bill—to provide civil immunity to physicians rendering medical treatment at the scene of an accident. Two such bills were introduced, one to provide such immunity for doctors only, and the other in broader terms, to protect any person rendering such treatment. Interestingly enough, the latter, which we favored, went through both Houses without opposition and, virtually, without the necessity of any effort on the part of the Association. We are particularly glad that such was the case. The overwhelming legal opinion seems to be that such statutes are unnecessary and perhaps ill-advised, and we think it is well that the Association did not have to become publicly involved in the passage in South Carolina.

Several bills relating to mental health facilities in the State were adopted. The most important was that which created the new Department of Mental Health, and transferred to it the activities of the former Commission. Following a special meeting of Council in February, differences in viewpoint between the Association's Committee on Mental Health, the Department of Health and the Commission on Mental Health were ironed out and adjusted. Proper amendments were agreed upon and introduced and the legislation adopted in a form acceptable to the several groups.

Another bill relating to community health centers provided that two doctors of medicine should be members of each such community board.

Several features of the State Compact arrangements as to patients of mental institutions, which had been enacted into law several years previously, were removed by amendment this year, in line with recommendations adopted by this House of Delegates at its session in 1963.

Throughout the remainder of the session, beginning in February our office kept the members of Council and of the Legislative Committee informed as to progress and status of the pending bills through a weekly report mailed to them each Friday. A great deal of additional mimeographed material had to be sent also to others requesting contacts in every county, and dozens of telephone calls made to keep in touch with the response to our efforts.

Relative to national legislation, the situation is just about as it has been for the past year. Last summer, we traveled over the State, cooperating with the Field Representative of AMA in presenting to various county societies "Operation Home Town," the AMA's then new campaign material against the King-Anderson Bill. The bill is still in the Ways and Means Committee of the House, and some action is expected soon. At a recent meeting in Chicago, we heard Dr. Ernest Howard, assistant executive vice-president, predict that the bill will be defeated this year. This does not mean, however, and he certainly did not recommend, that there can be any lessening of effort against it.

We have enjoyed during the past year, the normal cordial relationship with the officers of the Association, and once again express our appreciation to the President, Dr. Wilson; the Treasurer, Dr. Stokes; the Secretary, Dr. Miller; and Dr. Burnside, Chairman of Council. Dr. Burnside's presence will be greatly missed as a member of that body on which he has served with distinction for the past nine years.

The Chair: Thank you very much, Mr. Meadors. Jack, I wonder if you would present Dr. Ben Miller's report, Dr. Miller, our Secretary, is absent.

Mr. Meadors: Certainly.

Report of The Secretary

This annual meeting marks my completion of two years as your Secretary. These have been most interesting years and much has been learned about the philosophy and operation of the society.

The close association of the Secretary with Council has been very rewarding. The arduous task of Council is carried out with diligence and judgment. Most inquiries on placement were in the field of specialization. The Secretary could afford little more information than was to be obtained from the Directory of the Association.

The Secretary is the corresponding officer of the Association and it is his duty to inform the Governor's office of the various nominations by the Association for commission by the Governor. The American Medical Association is likewise informed officially of election as delegates and alternates, and various contracts made by the Association must be certified by the Secretary. Many of the details of the work of this office are expedited by the Executive Secretary, and to him the Secretary is deeply indebted.

I would like to acknowledge to the House of Delegates my gratitude for the opportunity you have given me, and for this privilege I thank all of you. (Signed) Ben N. Miller, M. D.

The Chair: That report will likewise be referred to the Reference Committee on Reports of Council and Officers.

Dr. Garrison has come in and that completes the Committee on Legislation and Public Relations.

Dr. R. M. Anderson has come in and I had asked Dr. Taylor to serve on that, but I notice he was on another reference committee, so I will ask the Committee on Public & Industrial Health, Dr. Swift Black, Chairman, Dr. Nigels, Dr. Anderson, Dr. Zemp and Dr. A. L. Rivers.

I think that completes all of the Reference Committees.

The next order of business is the report of the Treasurer, Dr. Howard Stokes.

Report of The Treasurer

Dr. Howard Stokes, Treasurer: The report of the treasurer is presented in a slightly simplified form. All figures are taken from the audit, which is also presented and which is to be published in the *Journal* along with the present report.

The report is as follows:

REVENUE

JOURNAL			
Advertising		$23,284.75	
Subscriptions		4,273.25	
Total Revenue from Journal			$27,558.00
GENERAL			
State Dues		$37,195.50	
Interest		5,740.25	
Directories		278.00	
Emblems		9.75	
Miscellaneous		550.43	
Benevolence Fund		462.50	
Total General Revenue			$44,236.43
TOTAL JOURNAL AND GENERAL REVENUE			$71,794.43
PERMANENT HOME FUND			6,882.50
TOTAL REVENUE			$78,676.93

EXPENSES

JOURNAL			
Printing		$21,855.84	
Editor's expense		1,241.76	
Clippings, etc.		150.40	
Salaries			
Editor	$1,800.00		
Editor's Secretary	466.67		
Advertising Manager	1,200.00		
		3,466.67	
Total Journal Expense			$26,714.67
EXECUTIVE OFFICE			
Rent		$ 1,500.00	
Office Supplies		911.48	
Executive Secretary Travel		2,541.20	
Salaries		19,871.25	
Furniture & Fixtures		355.42	
Miscellaneous Expense		552.18	
Total Executive Office Expense			$25,731.53

COMMITTEE ON PUBLIC RELATIONS

Tobias & Company		$ 1,901.08	
P. R. Institute		94.21	
J. I. Waring, Chm.			
Salary	$1,200.00		
Secretary	233.33		
Chm's Expense	506.74		
		1,940.07	
Total Expense, Committee on P. R.			$ 3,935.36
GENERAL EXPENSE			
A.M.A. Meetings		$ 1,646.81	
President's Expense		1,500.00	
Treasurer's Expense		100.00	
Tel. & Tel.		1,342.28	
Postage		709.96	
Insurance		1,129.40	
Newsletter		529.28	
Bookkeeping & Audit		415.00	
Taxes (Soc. Sec. & Fed. Unemp.)		698.29	
S. C. Unemp. Security Com.		145.99	
Legislative Service		500.00	
Dues & Subscriptions		355.40	
Public Relations		275.00	
Woman's Auxiliary		750.00	
Woman's Auxiliary Bulletin		820.86	
Historical Committee		500.00	
Committee on Infant & Child Health		10.00	
Misc. Committee Expense		534.43	
Directories		401.44	
Benevolence Fund		900.00	
Miscellaneous		297.33	
Total General Expense			$13,561.47
TOTAL EXPENSE			$70,733.55
INVESTMENTS			
Permanent Home Fund (Investors Stock Fund)			$ 6,992.50
Dividends Reinvested (Investors Stock and Mutual Funds)			5,740.25
			12,732.75
TOTAL INVESTMENTS & EXPENSE			$83,466.30

SUMMARY

Total income			$78,676.93
Total disbursements			83,466.30
		$ 4,789.37	(deficit)
	Interest to bank	167.36	
		$ 4,956.73	

ITEMS HANDLED WHICH ARE NOT REVENUE:		
A.M.A.-E.R.F.	$ 6,215.00	
A.M.A. Dues	58,480.00	
County Dues	310.00	
TOTAL INVESTMENTS:		
Investors Mutual Fund		$70,603.92
Investors Stock Fund (P.H.F.)		43,104.29
Peoples Federal Savings & Loan Co.		11,850.80

As Treasurer I again remind the House of Delegates that with the reinvestments of dividends from our Mutual Fund, amounting to $5,740.00 and with the placing of $5.00 per member in the Permanent Home Fund we operated at a deficit of $4,956.73 for 1963. However, if our expenses remain essentially the same this year the use of the $5.00, which was previously allocated to the Permanent Home Fund, should enable us to meet our expenses.

The Treasurer would again like, as he does annually, to thank the members of the household and particularly the Executive Secretary and his very fine and efficient staff for carrying out the bulk of the business of the Association. It has occurred to us there has never been a reason to duplicate the business in the Treasurer's office and the business office. Thank you very much.



Happy Treasurer, Dr. Howard Stokes.

The Chair: Thank you, Dr. Stokes, and I think I express the feelings of the House in thanking you for your efforts as treasurer over many years past.
The next order of business is the report of the Editor of the *Journal*, Dr. Waring.

Dr. Joseph I. Waring, Editor:

Report of the Editor of the Journal

As indicated previously to Council, the *Journal*, in common with all of the state journals, has been suffering from a decrease in the amount of advertising. Since our production depends almost entirely on income from this source, it has been necessary to reduce the number of pages in the *Journal* so that the average number runs around 65 pages rather than the 96 to 100, or more, which we formerly had.
This also means if we are to keep within our *Journal* budget, that we do not have quite as much room for as much scientific material as we had in the past. However, since there has always been great difficulty in extracting enough scientific material from the members of the Association this doesn't come out so badly from the Editor's standpoint.
The editor attended a meeting of the State Medical Journal Advertising Bureau in Chicago, and incidentally was elected to the board of that organization, and came away with a rather gloomy feeling for the prospects of additional advertising in the future. The situation goes back directly to the Kefauver proceedings against the pharmaceutical industry and since there appears to be no likelihood of any change soon, the probability of a return to the previous amount of advertising is small. The manufacturers apparently feel that they get a better return for their advertising dollars from such publications as *Medical World News, MD*, and the other so-called throw-away journals.
I believe that we have not fully exploited the possibility of obtaining local advertisements and I think this should be done. Our general membership could be quite helpful in this if it could be interested in doing what it can to interest local friends and acquaintances in possibly using the *Journal* as a means of advertising. There is no reason why we can't have a lot of things, such as automobile advertising, resorts, golf, etc., and as far as I know there is no bar to any kind of advertising except that of cigarettes and liquor.
We have made no major change in the format of the *Journal* except to include some advertising in the text, thereby earning a small premium on such advertisements.
Your editor is scheduled to attend the meeting of the Advertising Bureau in San Francisco in June.
Now, gentlemen, I did not mean to imply that the *Journal* was so well back-logged in scientific material that it is not anxious to have more. I am sure it has been through a number of crises when apparently there would be nothing for the coming months, but fortunately something has always turned up. I invite you cordially to submit scientific material, subject to the editor's judgment as to whether or not it should be published. Thank you.
(*Dr. A. C. Bozard*, Vice-President, at the request of Dr. Wilson takes The Chair and presides during the reading of the Editor's Report.)
Dr. Bozard (Presiding) Thank you, Dr. Waring. (The Editor's Report referred to Reference Committee on Reports of Council and Officers.)
The next order of business will be the Report of the Chairman of Council, Dr. Burnside.

Dr. A. F. Burnside, Chairman of Council:

Members of the House of Delegates, Council met this morning for possibly four hours and considered many things, and they made several recommendations to the House of Delegates.
The first of which is a motion, passed by Council and recommended to the House of Delegates:
That the funds now in Building Fund be utilized and that $49,059.00 be used to purchase the Bull Street Property in Columbia, S. C., and authorization be given for placement of $25,000.00 mortgage on this property and whatever is left beyond this be used for repair, furnishings, etc., and that the President, Treasurer, and Secretary be authorized to place such a mortgage. This refers to the property on Bull St., Columbia, S. C. Motion also includes that this be recommended to the House of Delegates at this annual meeting, and I so move.
Council appointed the Committee to make recommendations to it in regards to tetanus immunization and that Committee made the following recommendation to Council and Council endorses this recommendation. This is headed by Dr. Gibbes in Columbia.
It is recommended that, under the auspices of the State Medical Association, all local medical societies initiate mass programs to raise the level of tetanus immunity in their communities. It is recommended that especial emphasis be placed on the immunization of pregnant women and those of child bearing years, particularly those who will be delivered under non-aseptic conditions. It is recommended that in traumatic emergency room admissions, without previous tetanus immunization, immunization be initiated at the time of receiving antitoxin, and that they be given appropriate instructions to obtain further immunization elsewhere, as indicated.
It is further recommended that the State Medical Association provide the following aid and assistance:

1. Designate appropriate dates for such campaigns, to allow for more efficient ordering and distribution of supplies and equipment. The dates need not be the same statewide, but should be sufficiently consistent as to allow for an efficient mesh of publicity campaigns. Two appropriate times would be April/May or October/November.
2. Appropriate pronouncement should be provided those conducting the campaigns. Statements of approval by the State Board of Health, the Governor, other similar dignitaries—state or national—should be obtained and duplicated appropriately. Such statements are of considerable aid in obtaining cooperation from local organizations.

It is also recommended that the various societies give thought to the use of combined diphtheria-tetanus toxoid to insure added benefit to their communities.
A request came from Dr. Edward E. McKee, Professor of Pathology, Medical College of South Carolina,

asking Council's advice on the establishment of a special section of pathology, and Council goes on record as referring this to the House of Delegates for action.

That recommendation is:

"At a recent meeting of the South Carolina Society of Pathologists, the possibility of establishing a section in pathology within the organization of the Association was discussed. As you may know, the number of pathologists in this state has roughly tripled in the last ten years. Our current membership is twenty-six (26) and we are becoming more interested in meeting as a group for scientific programs and discussions.

"We understand that in the past, the state association has felt the establishment of specialty sections would be of little value because of the relatively small membership of the association.

"At this time we would like to ask the council if sectional organization might not now be of some value."

And Council recommends that to the attention of the House of Delegates.

That is all, gentlemen, and thank you.

The Chair: Thank you Dr. Burnside. That report will be referred to the Committee on Reports of Council & Officers.

Dr. Wilson, Presiding: The next order of business is the report of the Delegate to the American Medical Association, Dr. Johnson.

Dr. George D. Johnson, Delegate, AMA: Mr. President, Members of the House of Delegates, this year Dr. Cain and I have divided the two meetings. I will report on the clinical meeting and he will report on the annual meeting.

The Board of Trustees approved the following places and dates for the annual and clinical meetings for the next several years. The annual, as you know, will be in San Francisco, June 21-25, this year. Next year—New York, June 20-24. 1966—Chicago, June 26-30. 1967—Atlantic City, June 18-22. 1968—San Francisco, again, June 16-20.

Clinical meetings, this year, in Miami Beach, November 29-December 2; 1965. Philadelphia, November 28-December 1; 1966. Las Vegas, November 27-30.

In February of last year the Board of Trustees approved an eight-point program on the aging:—(1) Re-evaluation of attitudes toward the elderly; (2) Further implementation of the Kerr-Mills Law; (3) Changes in laws to benefit the aging; (4) Continued expansion of health insurance and prepayment plans; (5) Recasting employment policies; (6) Increase in nursing home facilities; (7) Expansion of community programs for the aging; and (8) Emphasis on mental health among the aging.

Changes in the Constitution and By-Laws of the American Medical Association were approved, at the December meeting. The Constitution was greatly shortened and the duties and terms of officers were removed and put in the by-laws where they should have been all the time.

It was emphasized in the report of the Board of Trustees that the program of research on tobacco will be entirely separate from the Biomedical Research Institute. In addition to the study of tobacco and its smoke products that might be poisonous or harmful the researchers were instructed to study the elimination of such elements, if at all possible.

In his speech to the House of Delegates in December Dr. Annis told of the testimony of the AMA before the Ways & Means Committee. The staff of the AMA worked long and diligently to dig up the facts. Kerr-Mills Bill at that time was in operation in 40 of the 54 states and territories. Mr. Mills forced the actuaries of the Department of Health, Education and Welfare to admit that the requirements would be doubled over their original estimate. Dr. Annis urges every doctor to continue the struggle against the socializing forces of the bureaucracies in Washington.

The following items were recommended to the constituent and component medical societies, and this notification was sent out to all large medical societies. The first was about restrictive membership provisions and they reaffirmed the 1950 resolution, which was sent to all constituent and component medical societies at that time. And I will have to read this verbatim so that you will get the full shade of meaning that was written into it.

"*Whereas*, the House of Delegates recognizes that certain constituent and component medical societies of the American Medical Association have had or now have restrictive provisions as to qualification of membership based on race and that the question is of deep concern to many interested parties; and *Whereas*, it is desirable that the attitude of not only the entire membership of the American Medical Association but of the whole medical profession be accurately reflected on this issue; and *Whereas*, it is the policy of the American Medical Association to broaden the scope of educational facilities and raise the ethical levels of practice of all physicians, in order to improve the quality of medical care for the American people; therefore be it

Resolved, that these facts be brought to the attention of all component constituent societies, appreciating that membership is a component and constituent society responsibility; and be it further *Resolved*, that constituent and component societies having restrictive membership provisions, based on race, study this question in the light of prevailing conditions, with a view to taking such steps as they may elect to eliminate such restrictive provisions."

And the Board of Trustees recommended that the House of Delegates urge that all component and constituent medical societies study the question of eligibility to staff membership in hospitals. As the resolution puts it, in the last resolve:

"*Resolved*, that members of the medical staff of every hospital, where the admission of physicians to hospital staff privileges based on race, be urged to study this question in the light of prevailing conditions with a view to taking such steps as they may elect to the end that all men and women professionally and ethically qualified shall be eligible for admission to hospital staff privileges on an equal basis, regardless of race."

All constituent and component medical associations are urged to write their senators and congressmen prohibiting the Federal Drug Agency from having the authority to remove from the market a drug which in its opinion is ineffective. Only physicians are qualified to make such a decision after widespread usage.

Community Health Project Grants:

"*Resolved*, that the House of Delegates of the American Medical Association recommend to the Public Health Service, U. S. Department of Health, Education & Welfare, that applicants for community Health Project Grants be required to consult with and document the reaction of the local county medical society and affected community groups in all community projects relating to personal health services."

Membership in local, state and U. S. Chambers of Commerce.

"*Resolved*, that the House of Delegates to the American Medical Association reaffirm its previously adopted recommendation to all state medical societies that they become active in the United States

and State Chambers of Commerce; and be it further *Resolved,* that a similar recommendation be made to all county medical societies so that they, too, might be encouraged to become active in local, state and U. S. Chambers of Commerce programs."

Position on Blood Banks.

"The American Medical Association's Committee on Blood believes that component and constituent medical societies should be informed of proposed and existing blood banking facilities within the community and should offer guidance to them. In the opinion of the Committee it is desirable that the organization of new blood banking programs and the modification of existing ones should have, in the interest of public health and safety, the approval of the county and district medical society and should be coordinated with existing, approved blood banking facilities."

Now, I want to thank you for the privilege of representing, as one man, the South Carolina Medical Association and I appreciate the opportunity to serve you. Thank you.

The Chair: Thank you Dr. Johnson. Dr. Cain, have you a report?

Dr. Joseph P. Cain, Jr., Delegate to AMA: Mr. President, fellow members of the House of Delegates, I wish to thank you, also, for the opportunity of representing you at the meetings of the American Medical Association. I can assure you that even though we have split these meetings up, that each of us attended both of these meetings. We didn't one of us go to one meeting and one the other, and the other one go to the movies, and vice versa.

I would like to call your attention to the positions held in the AMA by our senior delegate. Quite naturally it was not in his report to mention these things. George D. Johnson is a member of the Council on Constitution and By-Laws. That is quite a distinct honor. He also was a member, last year, of a special ad hoc committee of the Board of Trustees to consider sections of certain work; and he has been very active on reference committees. I think that you should know that because he is really making a name for himself and for South Carolina at the AMA.

It is my task to report the Annual Meeting of the American Medical Association which was held at Atlantic City, June 16-20 of last year. About 13,000 physicians, I don't mean wives and exhibitors, I mean physicians, were registered at that meeting. The retiring President, Dr. George Fister, told the opening session that "our fight against federal dictation is not merely one of concern only to physicians and their freedom to practice the best medicine possible, but it also concerns, equally or more so, the individual citizen, all professions and the private enterprise system in this country." Awards announced were the AMA Scientific Award which went to John F. Enders, Ph.D., of Boston, and the Joseph Goldberger Award in Clinical Nutrition to Dr. John B. Youmans of New York City.

Dr. Norman A. Welch of Boston, member of the House of Delegates since 1951 and speaker of the House since 1959, was named president-elect. He will succeed Dr. Edward R. Annis of Miami, Florida, who is to be our guest speaker today, who assumed office at the Tuesday night inaugural ceremony in Atlantic City.

The AMA 1963 Distinguished Service Award was voted to Dr. Lester R. Dragstedt of Gainesville, Florida, research professor of surgery at the University of Florida School of Medicine, for his achievements in the fields of education, research and practicing surgery. Also Dr. Dragstedt is one of our guest speakers at this meeting.

The House adopted certain amendments to the Constitution and By-Laws. The changes will increase the size of the Board from 11 to 15 members. The term of office for elected Board members was set at three years and the number of terms limited to three, for a maximum total of nine years service. It is hoped that this will improve communications between the Board and the Association and will be consistent with the increase in membership of the Association and with the increase of the size of the House of Delegates.

Concerning AMA Sections and Scientific Program

All section officers—chairman, vice chairman, delegate, alternate delegate, secretary, assistant secretary and representative to the scientific exhibits will be elected by members of the section and no officers will be appointed by the AMA Board of Trustees.

Relating to nominations for specialty boards, the House approved the following recommendations: "The Committee of the Council on Scientific Assembly of the appropriate section shall nominate the AMA representatives to serve on the medical specialty certifying board. These nominations shall be submitted to the Board of Trustees."

In connection with section registration, the House decided that "a member of a section who desires to change his registration from one section to another because of a change in his specialty, shall be required to inform AMA Headquarters by written notice of this intention at least sixty days in advance of the Annual Meeting."

The Section on Gastroenterology and Proctology was renamed the "Section on Gastroenterology" and a separate "Section on Proctology" was established.

The Board of Trustees was commended for its recommendation that a national forum be sponsored by the AMA in which representatives of national medical specialty societies and the Academy of General Practice will participate.

Concerning Interns and Residents

The House disapproved the report of the Council on Medical Service and the Council on Medical Education and Hospitals on Compensation of House Officers. In so doing, it adopted the following resolutions:

> "It was recommended that in view of the overwhelming opposition to the basic proposal contained in the report of the Council on Medical Service and the Council on Medical Education and Hospitals, the AMA record itself as opposed to any system or program by which any part of an intern's or resident's salary is paid out of fees collected by the attending physician or out of fees collected under any type of medical-surgical insurance coverage."

In another action, related to the controversial "25% rule" the House approved a revision of the "Essentials of an Approved Internship" which deletes the requirement for any stated proportion of foreign medical graduates and graduates of American and Canadian medical schools as an essential feature of any internship program.

Dr. Johnson has already spoken about the Research Institute, which was inaugurated at this session and which was clarified later at the Portland session.

Physicians' Pension Plan

The House approved establishment of an AMA physicians' pension plan under the provisions of the Self-Employed Individuals' Retirement Act of 1962, and noted that the Board of Trustees will make every effort to begin operation of the plan before the end of 1963 so that physicians will be able to participate this year. Of course, this is almost the middle of 1964 and that has not been implemented yet. The plan ran into trouble with the security exchange commission so far as the investment plan was con-

cerned, however the insurance plan has been approved.

Tobacco and Disease

The House agreed with a Board of Trustees report which concluded that the AMA should defer any definitive statement regarding the relationship of tobacco and disease. The report pointed out that the AMA is continuing its study of this important subject and is merely deferring any public pronouncement pending the availability of more information, including whatever may come from the study of a committee appointed by the United States Public Health Service. You will notice all of these actions, taken on the study of tobacco, were taken prior to the issuance of the report by the Public Health Service.

In taking this action, the House declared that extensive research is still necessary for the complete answers on the cause and effect of many toxins, including tobacco. However, the House said that the AMA "has a duty to point out the effects on the young of the use of toxic materials, including tobacco, and these facts should be disseminated, particularly in our schools."

The House also considered a wide variety of resolutions and reports. It disapproved a Judicial Council opinion on the dispensing of glasses by ophthalmologists and reaffirmed the Council's interpretation of Section 7 of the Principles of Medical Ethics, as reported in the November 1958 issue of the *Journal of the American Medical Association.* This was disapproved as long as the welfare of the patient is not exploited in any way.

It approved a Judicial Council opinion on physician ownership of drug stores. It approved that. But drug repackaging houses and pharmaceutical companies entirely owned by physicians—it declared that that was not ethical.

It approved of AMA participation in the recent formation of a Joint Commission on Medicine and Pharmacy.

It agreed with the Council on Legislative Activities that the House should take no official position on the "Liberty Amendment" but should call it to the attention of individual physician citizens. That should be of interest to us because a resolution concerning that has been introduced in our House of Delegates in the last two or three years.

It disapproved of federal funds for staffing new community mental health centers.

It took a position opposing the student loan provisions of the Health Professions Educational Assistance Act of 1963.

It urged all state and county medical societies to adopt and activate all phases of "Operation Hometown." And this, I think is a particularly good resolution that we should pay particular attention to, whether we do it on the state basis or whether we do it on a local basis. I say this because the students in our medical colleges are not always in accord with the views of the American Medical Association, particularly I have reference to the Student Loan Provisions of the Health Professions Educational Assistance Act. They approved it and we disapproved it. That is one example.

The recommendation was that local medical societies in the vicinity of medical schools assume the responsibility of establishing and maintaining clear lines of communication with medical students. In other words, we ought to let them know what we are thinking, as well in turn like to hear what they are thinking.

It approved the organization of the new National Council for the Accreditation of Nursing Homes, jointly sponsored by the AMA and the American Nursing Home Association.

It adopted the recommendations of the Committee to Study the Joint Commission on the Accreditation of Hospitals and suggested that the committee's report be distributed to constituent and component societies and hospital chiefs of staff.

It approved a change in the Association By-Laws which states: "The Council on Medical Education and hospitals shall consist of 10 Active or Service members at least one of whom shall be a private practitioner of medicine who is not a faculty member of a medical school nor a member of a staff of a hospital associated with a medical school or university."

It commended the American Farm Bureau for its vigorous leadership in opposing unwarranted government interference and regulation.

It urged the widest dissemination to AMA members of a joint report by the AMA Council on Mental Health and the National Academy of Sciences-National Research Council on The Use of Narcotic Drugs in Medical Practice and the Medical Management of Narcotic Addicts.

It recommended that all AMA members and affiliates give strong support to the national tuberculin testing campaign proposed by the American School Health Association.

It directed the Speaker of the House to appoint an ad hoc committee to study the size, make-up and functions of the House of Delegates, its councils, sections and committees and to report its findings in June, 1964.

Those are the principal recommendations and resolutions that were discussed at the Annual Session last year. Thank you very much.

The Chair: Thank you very much, Dr. Cain. The report of Dr. Cain is referred to the Committee on Reports of Council and Officers.

The Chair: I think we should go ahead with our Special Order, now, and have Dr. Annis come in, he has just arrived, I understand.

(Dr. Annis is escorted to the speakers stand amid applause)

The Chair: It is my very great pleasure and privilege to present to the House of Delegates Dr. Edward R. Annis of Miami, Florida. One could say a great deal about him, he is a superb speaker, an able physician and a magnificent leader of American medicine. I will not say anything more other than to present to you the President of the American Medical Association, Dr. Edward R. Annis. (Applause, and Convention stands.)

Dr. Edward R. Annis: I appreciate your invitation. I welcome the opportunity to be here. I know that some of you will be subjected to some of my observations this evening and so I thought, because you are the elected representatives of this whole state and represent its physicians, that you might be interested in a little contrast between medicine in these United States and medicine in some other segments of the world, especially in view of the recent castigations which doctors in Belgium, for example, have been subjected to, (not so long ago the doctors in Saskatchewan) and the general criticism which arises whenever doctors attempt to defend the things that they feel to be right. I don't know enough about what goes on or rather went on in Belgium to report to you factually, however, I was in Europe when this alleged strike began. The information given to me then from doctors from West Germany, from Paris and from London, indicated it was similar to what was proposed in Saskatchewan, and similar to what has been proposed in several other areas of the continent but which has not yet come to fruition. There was no strike in Saskatchewan. Oh, I know the liberal

press has said that there was but there was no strike. And when I am often asked this question by representatives of the communications media, the press, radio and television, before I answer them and tell them what did take place I ask them this question: if working for your newspaper or radio or television studio you felt that your conditions of work were not satisfactory, that you were not being paid enough, that you were working too many hours, that you didn't have enough help or facilities, or what have you, and if you were to go to your employer and say "We want this, this and this or we will strike, we will refuse to work" that is a strike. But, let's assume you came to work this morning and you read that the Government is proposing a law which will take effect June 1st, and the law will say this "After June 1st you may work for no one but the Communications Division of the United States Government, you may work for no newspaper, no radio station, no television station, we are taking the communications industry over, you will work only for Government and if you work for anyone else it will be in violation of the law and subject to the sanctions of the law; and to begin with we will pay you 85% of what you were working for three years ago." I asked them, would this be a strike if you said, "Well, I will go back to farming, or I will no longer work in communication" or in truth would you not have been locked out, as an individual, from working in the communications field where by training and experience you have secured yourself?

This is what was proposed in Saskatchewan. The proposed law said "that as of July 1, 1962 it would be against the law to practice private medicine in that province," and to begin with they were going to reimburse the physicians at 85% of their fee schedules, similar to the Blue Cross - Blue Shield schedule which has been adopted three years before in 1959, and the proposal would have made it against the law and subject to the sanctions of the law for any doctor to continue to practice private medicine. This is quite different from a strike. Some 160 or 170 said they would not work under those circumstances, so they left the province.

In these United States it would have been a direct violation of the 13th Amendment to our Constitution which says "No man or no woman will be ever subject to involuntary servitude." You don't have to work for anyone against your will.

This was what was proposed in Saskatchewan. Of course, they backed down, and from the doctors, who were with me in Luxemburg, this is what allegedly was proposed in Belgium, where they had so much trouble.

I cite those only as an example of the distortion which often reaches the writers and the readers of our newspapers in this country; the writers because they get only from the various services, that which comes over the wire; and the readers get only that which reflects the views and in this instance reflected discredit to the physicians.

I read in a couple of religious publications that doctors were violating their moral obligations because they refused to accede to the demands of the law in the interest of the people represented by the Government. And these theologians suggested that if the doctors didn't like the law they could try to change it, but meanwhile they should be subject to the law. I happened to meet one of them not long after his utterances appeared in print, and I asked him this question: "Hitler was the law in Germany and when he passed a law and he told the doctors that they would perform certain operations and sterilize certain women, in their hospitals, for the use of his troops, should the doctors have obeyed the law or should they have stood up for those moral principles for which medicine has always stood and defended the moral rights of the individuals who happen to be their patients?" "Oh," he said, "That is different." I said, "That is different because you disagree with what Hitler said but you agree with what you think is taking place in Belgium, as you probably did in Saskatchewan."

I cite these as examples, some of the ways in which our enemies will use the happenings in other countries, distort its picture, in an attempt to discredit physicians everywhere. Our enemies are charlatans, politicians with another ax to grind who would misuse the health of the people for political purposes; and some labor leaders' socialistic philosophies have too long dominated some segments of the American scene. These are our adversaries, these are the ones we have to fight. But those we are responsible to are our patients, the American people. And if a profession has lost the respect of the people, either there is something wrong with the profession or there is something wrong with the people. And sometimes it isn't anything wrong with them, but it is wrong with the kind of information or misinformation to which they have been exposed. You and I and the members of our profession, for a long time, have been vilified by those with another ax to grind. For too long a time they have been pointing the finger to the cost of medical care without talking about its worth. Some of the other things I will talk about this evening. But I would like, in the next few minutes that I have, to tell you a little of the answers that I found to questions which arose in my own mind—not once but many times—during the past three and a half years. Over that period of time I have met many physicians from other lands, especially from England. Over that period of time I have met and discussed the matters of government medicine with representatives of English government medicine, as well as clinicians and visitors in this country. Time and again in meetings such as this I have seen on the program outstanding clinicians, men well-known in international medicine, who would appear on your program and speak on the subject of plastic surgery, or surgery, or medicine, or research and they were given the proper recognition that their scientific position in the profession demands, and which they deserved. And then they would have an interview and they would be asked "How is it in England, for example?" And they would say, "Well, it is not really quite as bad as it has been pictured." "Well, how do the doctors do over there?" "They do very well. Doctors are progressing extremely well under this system, and the patients, on the whole, like it. Doctors aren't complaining about not being able to make money and the patients wouldn't think of changing." And I used to wonder how this could be true of men who are appearing on a scientific program, known for their honesty and their accuracy, and how it jibes with some of the other things that I was hearing from other physicians, some of the things that had been admitted to me by some of those who hold positions in other countries. I think I have found the answers to some of those questions and I would like to illustrate them to you now. In a general way I can say this. Two things impressed me in the three and a half weeks that I was in Europe. No man can be an authority in three weeks on anything, but I went there not to visit. Every day I had appointments with men in private practice, in hospital practice, specialty practice, in general practice and those charged with the responsibility of carrying out the Government's system, from ministers of health and in two instances ambassadors from other countries. I found two things, I came away with two grand impressions. One, the medical

profession has been subjugated to government dictation because it was first departmentalized and fragmented and had no uniform voice in any of their countries, and they played one against the other and one group against the others and they did it successfully, as well, and the doctors are the first to tell you that is true today. Secondly, there is no place for young men and women in medicine today. They have to wait, and the wait may take five, ten or fifteen years because they are waiting to fill places of people retired or to fill dead men's shoes.

What I found in England I had already seen in Paris and in Rome. In going through the hospitals and visiting there in one of the most famous surgical clinics in Rome I made rounds with a young man and spent a day there, who was in his sixth year surgical residency and had never performed a major surgical procedure on his own. I saw another one there who had been there ten years. Oh, he was filled with theory and the doctors who taught him said "over here we have great theoretical training but we don't have the practical training that you have in the United States." I asked these men why they didn't go out into practice. They said they couldn't because under the system, dominated and dictated by government, they could not even use the facilities of a hospital until they had been designated as a consultant on the staff of that hospital. And they had built no new hospitals to take care of the ever increasing number of young men and women who were trained.

So, it would be wrong to say that they don't have good doctors there, good surgeons, good internists, good researchers. It would be wrong to say they are not teaching good medicine. But it is right to say that they have well-trained residents, knee deep in ability, and no place to go. Every place I went they asked me what their chances would be to get into the United States, what their chances would be to come here, to become a citizen and to practice medicine.

Many of these were well-trained people. I won't dwell on Rome or Paris, because I would like to tell you the story of London.

It is the one which has been most misrepresented to the American people and to the American physician. To begin with I did not see one person in England—taxicab drivers, the workers in the hotels or anyone, and I talked to everyone from those who were around the Buckingham Palace and the rest—I didn't find one person who would change their system of socialized medicine. I might also say I didn't find one person that could tell the difference between good and bad medicine, who held that opinion. I did ask this question "How long since you have been to the doctor?" In one instance it was a week, another one a couple of times last month and it would be anywhere varying from a few weeks to a couple of months. "Did he take off your clothes and examine you?" "Oh, no, I wasn't that sick." I asked a number of doctors "How many patients do you see in a day?" The number went from 40 to 60. "How many do you examine in a day, take off their clothes, listen to their heart and take their blood pressure?" I didn't meet any that would say more than a couple or two or three. "Well, what do you do?" And the answer was, "Well, I am a sorter. People come in, most of them don't have much wrong, you write out a predence suggesting anything more serious, they are sick you send them into the hospital." This is the kind of medicine anyone could have when they want to, and I don't deny it. If they are really sick, if they have a heart attack or a stroke, or if they have evidence suggesting anything more serious, they are sent into the hospital and there they have good doctors, well trained and again they are knee deep waiting for someone to retire. I went to the only hospital built since the war from the bottom up, the new Guys Hospital in London. I had previously gone by—did not go into detail—in St. Martin's and across at St. Thomas, where Florence Nightingale got started there, and 18 years after the war you still see the walls remaining, partially destroyed by the bombs of Hitler. Only today are they cleaning up the basic rubble and beginning to reconstruct these hospitals after 17 to 18 years, because medicine has been totally the responsibility of government and medicine, and all of its things that pertain to it, its hospitals, and research centers have had a very low priority because doctors of medicine and scientists of medicine have had little or no say as to whether or not medicine should have a priority.

I talked and made rounds at Guys. The young man with whom I made rounds there was in his seventh year as an intern, seven years hospital training, hopeful that he would be given an appointment. "What is your chance?" I asked him. He said "Well, there are 20 openings and 82 applicants." I said, "What will you do if you don't get an appointment to a hospital?" And again, they have only built one hospital in 18 years, we have built 900. There are a lot of places for our young people to go. No places for theirs until someone retires or someone dies. I said, "Well, what will you do if you can't get an appointment?" He said, "Well, I will stay on at Guys." I said, "What if you don't want to do that?" He said "Well, I could go to the States, go to Australia, or I could go into general practice, but of course, I wouldn't want to do that." I said, "Tell me," (I knew the answer before I asked it) "If you were out here and wanted to go out and say, practice about a mile from Guys Hospital, because let's say you were going there because you know the people in the neighborhood, could you do that? He said, Oh, no, not unless I was assigned under the system." I said, "Let's assume that you did go there, because you were assigned, and here you have been getting specialty training, you have been running this whole hospital's medical service, with your assistants during the Easter week-end, while the consultants are off to the country with their families and the things you have taken care of here were to come to you in your practice—say a diabetic coma, a heart attack or a stroke, could you send them into Guys?" He said, "Oh, yes." I said, "Could you continue to take care of them?" He said, "Oh, no, general practitioners have no right in a hospital. I couldn't take care of them I would have to turn them over to whoever is on service. But, they would get good care and attention because," he said, "we have all kinds of people here with training to take care of them. They are just waiting for a place to go, to get an appointment under this system." So, whether or not the facilities are available—it is not a question of knowledge or ability or training, but a question of whether or not, under the system, they have an appointment. This young man is 32 years old and hopeful that one of these days he may be able to get that appointment and begin the practice of medicine. So, I asked another. Mind you, I am asking a specialist now. I said, "Do any general practitioners have hospital privileges? He said, "No, not in London or Birmingham or any of the big cities, but out in the smaller communities very often they can because there are older consultants there who know the physicians and know their ability and in these instances the strength and the position of the older consultant makes it possible. But, by and large, across England, unless you are a specialist with a consultant rating you may not use the facilities of a hospital and, of course, we have built no new ones." "Now, do I understand, also—

let's assume you go into general practice, you go out into an area and you have 2500 people on your panel for which you would get approximately $12,000 United States dollars, and they estimate when they set it up 17 or 18 years ago that 30% would be the cost of overhead and they allocated it. The purchasing power, of course, is about twice of what ours is. And over here you go into practice with 2500 patients—and over here is another general practitioner who has not had your training or ability, has no particular desire to be anything but a "sorter," as some of them told me they are, but let's say because of your training you want to be a good physician, you want to be able to diagnose diabetes and these other conditions early so you buy a microscope and other laboratory equipment, you may buy a fluoroscope, you may buy a cardiograph or an x-ray machine and you have to hire a technician, do they give you any more money for all of that?" He said, "No, you have to pay for all of that out of your $12,000." He said, "It is one of the unfortunate things of our system, doctor, that the better the quality of medicine practiced, the less one gets in return."

Imagine a system that puts a priority on those less efficient and who render a lower quality of service. This could have been a distortion, this could have been somebody with a gripe, it could have been a gripe from the general practitioner and it could have been a gripe from the internist waiting to be a specialist, who agreed with the general practitioner. But my final confirmation that it is true was two weeks ago, Monday, when I sat alongside of Sir Charles Guys, President of the Royal College of Physicians. I recounted to him what I have told you and I asked "Is this true?" He said, "Yes, doctor, unfortunately under our system it is true. These are some of the things we hope to change. There is no place for young men until an opening is made available, and until we build more hospitals there won't be. And the general practitioner really has no place under our system because, of course, there is no way he can improve his lot nor can he practice the things that he knows how to do." I asked the young man "Is this the way all the general practice operates?" He said, "No, in some instances it works out jolly well good." He said he had two local friends, one was a general practitioner, who demanded respect from his patients, and he also in turn gave them attention and respect and practiced good medicine. He said for two weeks he covered this man's practice and in those two weeks he never was called after 11:00 o'clock except on two occasions, both of them for seriously ill patients and both of them he sent to the hospital. But he said this man had a rule he would make no home calls unless the call to him was made before 10:00 o'clock in the morning. And he said, "Boy, if anybody called him at any other time, except for a real emergency—he would just eat them out." Those are not the exact words he used, but the best for the record. Then he had another two weeks with another physician. He said the physician hated the system, hated working under it and wanted to get all he could and cared little for his patients and they thought the same of him. In two weeks time he had 18 phone calls after 11:00 o'clock at night, he told me they would wait until they got home, had their dinner, saw their favorite TV and then they would call the doctor. And if they ring you up at 11:00 and say "Doctor come see my wife" and you say "What's the trouble?" They would say "Come up and find out." And if you didn't go, oh, then you might be called before a magistrate because you refused to respond to a legitimate call from one of her majesty's subjects. So, he contrasted—he said a man could practice it, but under great difficulty.

I still couldn't figure out how this worked. I knew the consultant set-up. A man who works full time is one who works 11 units, five and a half days, a unit being a half day. I found that there are two or three of these in high positions in the big hospitals that made the equivalent of $36,000 to $38,000 before taxes and in this country that would be the equivalent of about twice that, in purchasing power, and they do very well indeed. But the real sharp consultants are those who take four or five units, 4-half days, or 5-half days and then they are known as a consultant to the Queen, in such and such a hospital and they have their private offices. Oh, here is where they take care of private people. And it is not one but a dozen doctors said "Under the system I am paid for people I used to take care of for nothing, and I have my private practice on the side and we do pretty well, as you fellows would say in your country." I still could not understand the general practitioners. They were not complaining in terms of dollars, either, until I found out that they, too had private practice on the side. When I visited with Dr. Derrick Stephenson, the executive vice-president of the British Medical Association, in his home, a nice little community about 50 miles from London, I asked, "what is the caliber of doctors here?" He said, "Very fine. We have some fine general practitioners, they get along well with the consultants, we have a high quality of medical practice," he said, "Our doctor lives over there on the hill." And I said, "Well, if you were not Dr. Stephenson of the British Medical Association, but merely John Jones, what would be the incentive for you to hire this doctor as a private physician, why not call him under the system?" "Oh," he said, "Time and service. Under the system I can go and wait in line until I see him and he will write out a prescription, in most instances. But, I can call him as a private patient and say "Doctor, will it be convenient for you to drop by along about 4:30?" And he will say "Of course." And he will come by and he takes off my shirt and examines my heart and lungs and checks my pressure and I get what you fellows in the States call "private attention." But, under the system —and this is what people don't realize—once you choose a private physician, nothing under the system is available to you. This is not true in Rome, this is not true in Paris. It is true in England. You can't go into the hospital and have the Government pay the hospital or a part of it and you pay the difference—oh, no, if you take a private physician you pay hospital, doctors, drugs and everything. A woman having her first baby can have a doctor in the hospital. After that, the second one, a mid-wife at home, and they deliver about 85 out of 100 babies delivered in England today. Or, you can have an obstetrician but if you do then you pay the obstetrician, the hospital, the drugs and everything just as you do in these United States. These are some of the things that people over here don't understand. These explain many of the things which in my mind had been unexplained.

The physicians admitted the system wasn't good. Dr. Stephenson had to leave the meeting at the World Medical Association, Luxemberg, to go home to Britain because of a threatened breakout between the specialists and the general practitioners. And when I talked to him the following week-end, at his home, he said "It wasn't over dollars, it wasn't over money, but that the General Practitioner has no status whatsoever. He is not even looked upon as a professional being. He is like an ordinary clerk or tradesman, more so, because he is at the beck and call of people anytime they want to call him." A

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1. Roach, T. C.: Therapy of Peptic Ulcer, J. Louisiana Med. Soc. *115*:136-139 (April) 1963.
2. Steinberg, H., and Almy, T. P., Drugs for Gastrointestinal Disturbances, Chapter 21, in Modell, W. (editor): Drugs of Choice —1964-1965, St. Louis, The C. V. Mosby Company, 1964, p. 343.

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few, by virtue of their personal ability have commanded attention and respect and run pretty good practices, but by and large it is a real battle for great numbers of them. The complaint, as he said, is not lack of dollars but that they don't have an opportunity to be respected as physicians, no place to improve the quality of their knowledge and their ability, no place to practice the things which they have learned.

These are a few of the capsules of things that I picked up. Some of the things that I went over to find out because they were unanswered questions in my own mind. In June I go into Scandinavia and already have appointments in four of those countries with those who are administering their system, for these much smaller countries, admittedly, where they are supposed to be working much more efficiently and better. But, at least, this is a different picture from what we have heard. It explains why the English people, many of whom never had doctors before and now can have a doctor merely for the going to see them, feel that this is a wonderful system. It explains what your friends and mine, who make trips to Europe and then talk about the little girl on the ship who had the acute appendix. She went in, they took out her appendix and she came back, it cost them $10 or $12 and they think, "Oh, this is great." And somebody broke a hip and they were taken care of, they were pinned and properly treated and they said "They have got a great system." Where would an acute appendix and a broken arm or a broken hip not be treated if a physician there had any kind of knowledge and ability to treat them? These emergencies impress our non-medical friends. And the quality of medicine available to them, once they get into the medical center, when it is available, is good. But, not one of these countries has available to its people, even in the big cities, the kind of hospitals that I have seen in this nation of towns of 5,000, 8,000 and 10,000 people with the diagnostic facilities, the x-rays, the laboratory equipment and the doctors with the knowledge to bring to them high quality medicine. This is where we differ. In some cities, in some hospitals, from some doctors, some people get high quality medical care in almost any big city of the world—but in no other country do they have the distribution of quality which is available in cities, large and small, throughout these United States.

It is a question of voluntarism as opposed to Government domination. As soon as it is the Government's responsibility to provide for the people, then individual responsibility and leadership and dollars falls off into nothing. And yet the reason we have 9000 hospitals in this country is because every time a new community rises up, we will say in a defense area, they build homes, and then schools and then churches and then they say "we want a hospital." Oh, there will be some that say "yes, the Federal Government, through the Hill-Burton Bill." This is not true. This arises where individual people say we want it here, we want it for our old and for our loved ones, we want good facilities that will bring good doctors. And this is where they have gotten them across this land. Admittedly, they may get some Federal funds. But last year, of the 428 millions of dollars spent of Hill-Burton Fund, generally, 116 million was supplied by the Government but 300 million—almost three to one, was supplied by local people in local communities. The motivation is by people who have the responsibility to provide for themselves and their loved ones and willingly do it, under our system. This is why the issue is one of voluntarism as opposed to central control from Government.

And those of you who have the opportunity to visit in these lands, take time to visit the big hospitals and you will see good clinics, you will see good surgery, good medicine, fine laboratories, and then go away from the big cities and the big hospitals and talk to doctors who practice in both kinds and compare that with what you know to exist right here in South Carolina and you will know why we better redouble our efforts to defend the principles which we know to be sound and leave responsibility of Government only to those who are unable to provide for themselves.

The Chair: Thank you very much Dr. Annis for the wonderful and inspiring talk and we will look forward to hearing from you a little later.

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(To Be Continued)

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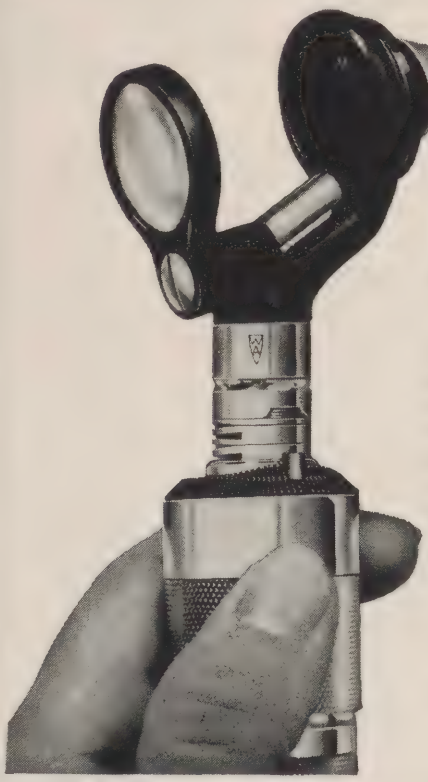
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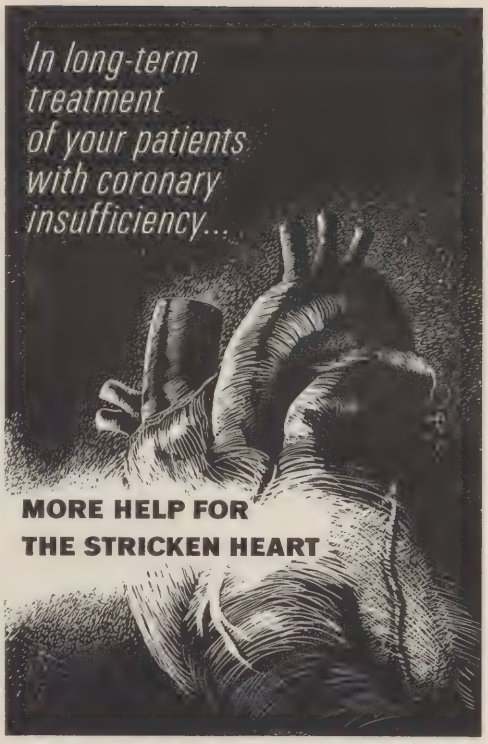
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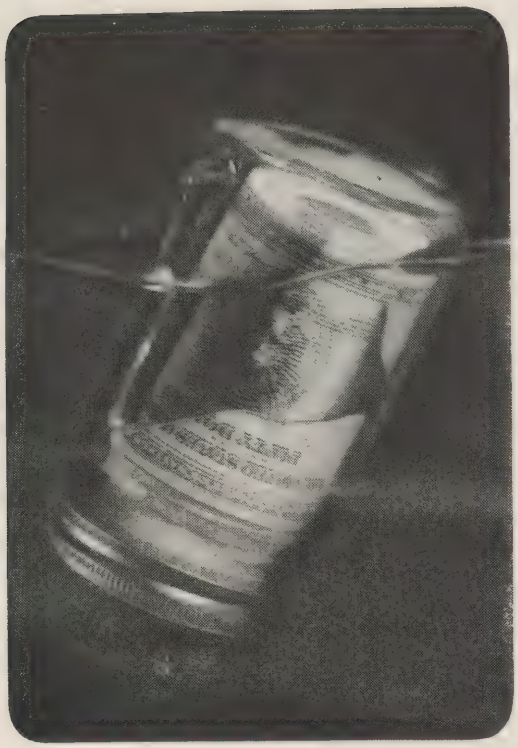
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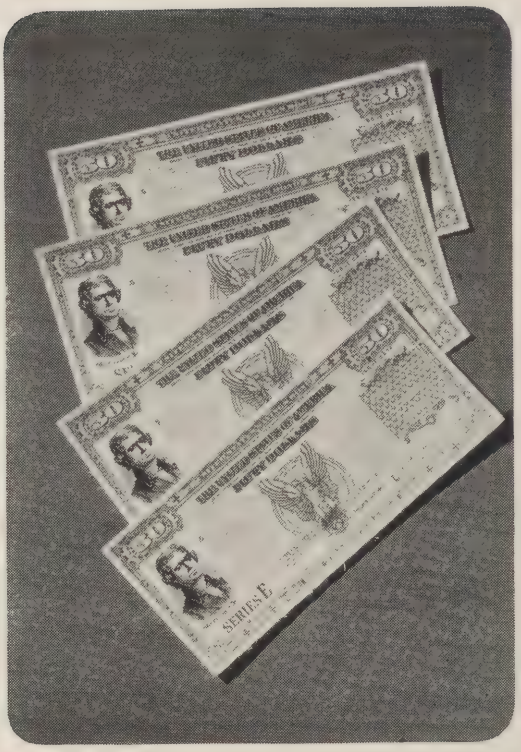
Side effects: Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. **Precautions:** Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. **Contraindications:** Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma. *Complete product information available in the product package, and to physicians upon request.* **Dosage:** 1 to 2 tablets, *before meals* and at bedtime. Individualization required. **Supplied:** Bottles of 50 tablets.

CML-1055

MILTRATE®
meprobamate 200 mg. + pentaerythritol tetranitrate 10 mg.

WALLACE LABORATORIES / *Cranbury, N. J.*





Waterlogged in Warsaw

Mention flooded basements to Lloyd Adams of Warsaw, New York, and he'll probably take a friendly swipe at your head.

It all started when Mr. Adams buried a glass jar containing $1625 in Savings Bonds under his home. A heavy rainstorm, an unusual amount of seepage, and a leak in the jar produced a gummy wad that bore little resemblance to the former family savings.

Fortunately, the Chicago office of the Treasury Department could check the record of Mr. Adams' purchase, and issue new Bonds—no charge. (Mr. Adams sent them the serial numbers, but the Treasury could have traced the Bonds even if he hadn't.)

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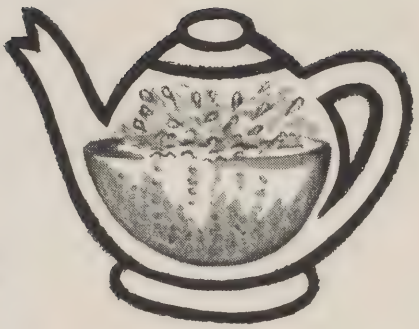
Every Bond purchase is recorded on film so it can be quickly traced, and the Bond replaced if lost or destroyed. This helps make Savings Bonds one of the safest places in the world to put your money. Uncle Sam guarantees it.

And incidentally, the more Bond dollars you lend Uncle Sam, the stronger our country will be. And the straighter Uncle Sam can stand up for freedom. Aren't those both pretty good reasons for you to buy Bonds?

Help yourself as you help your country

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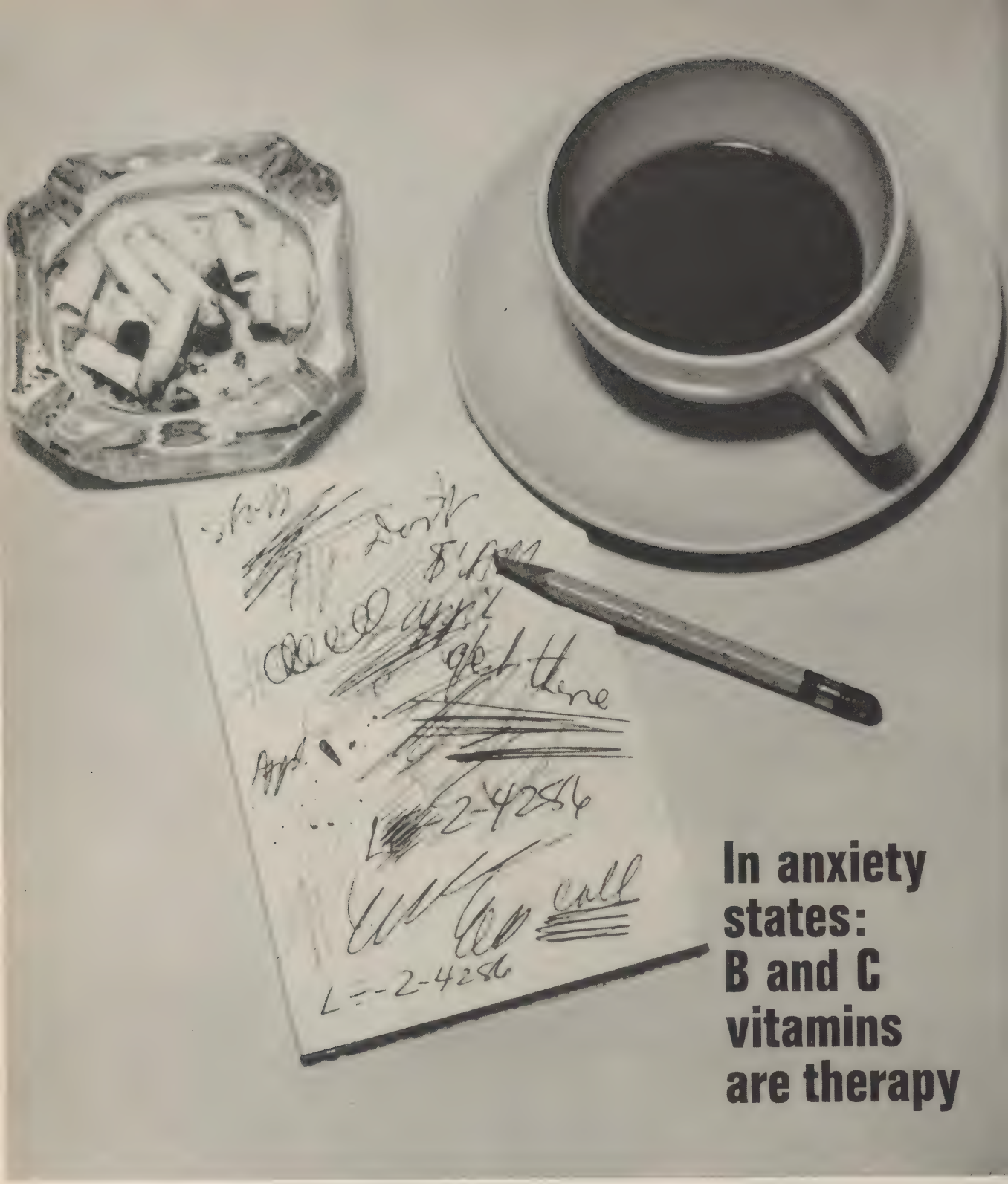
antacid—antispasmodic

SPASMASORB combats gastric discomfort and pain by forming a protective coating over mucosa, reducing acidity and inhibiting spasm. Indicated in the treatment of peptic ulcer, gastritis, cholecystitis, biliary dyskenesia, spastic colitis and gastrointestinal spasm. Contains ADIPHENINE HYDROCHLORIDE, a parasympatholytic agent and highly effective antispasmodic that acts directly on the smooth muscle, with local anesthetic effect on gastric mucosa; PHARMASORB, known for its distinctively high adsorptive and marked acid neutralization properties; and PENTOBARBITAL SODIUM, an efficient mild sedative and spasmolytic that is of particular value in the relief of pain due to smooth muscle spasm accompanied by "nervous tension." CAUTION: Federal law prohibits dispensing without prescription.

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In anxiety states: B and C vitamins are therapy

Stress formula vitamins are an important supportive measure in maintaining the nutritional status of the emotionally disturbed patient. With STRESSCAPS, B and C vitamins are present in therapeutic amounts to meet increased metabolic demands. Patients with anxiety, and many others undergoing physiologic stress, may benefit from vitamin therapy with STRESSCAPS.

Each capsule contains:

Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

STRESSCAPS®

FOR PROFESSIONAL RECOMMENDATION ONLY

Stress Formula Vitamins Lederle

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The patient's complaint is indigestion...especially of intolerance to fried foods...aggravated by stress. You diagnose functional G.I. disturbance and associated stress...as manifested by flatulence, "nervous" indigestion and constipation. Prescribe

DECHOLIN-BB®

(Hydrocholeretic • Antispasmodic • Sedative, AMES)

Each Tablet Contains:

BUTABARBITAL SODIUM.....15 mg (¼ gr)
(Warning: May be habit forming) to ease nervous tension

DEHYDROCHOLIC ACID.....250 mg (3¾ gr)
to produce large volume of watery bile, hydrate the bowel contents and gently stimulate the intestinal mucosa

BELLADONNA EXTRACT.....10 mg (⅙ gr)
to reduce smooth-muscle hypertonus

Average adult dose: 1, or if needed, 2 tablets three times daily. *Precautions:* Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction. Caution drivers against possible drowsiness. *Side effects:* Dehydrocholic acid may cause transitory diarrhea; belladonna — blurred vision, dry mouth. *Contraindications:* Biliary tract obstruction, acute hepatitis, glaucoma, and prostatic hyperplasia. *Available through your regular supplier:* DECHOLIN-BB, bottles of 100 tablets. 72664

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Outwardly calm...but what goes on inside?

Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

Consider, when you see him next, the value of PATHILON® SEQUELS® with Phenobarbital, which provides sustained anticholinergic protection from spasm and pain in the target areas, as well as sustained phenobarbital action against triggering anxiety. The controlled release of the active ingredients in the SEQUELS® formulation means protective medication day and night.

Effective in peptic ulcer, intestinal colic, ileitis, esophageal spasm, spastic colon, alcohol-induced G.I. upsets, gastric hypermotility and anxiety neurosis with G.I. symptoms. Should be used as adjunct to other measures.

Side Effects (due to tridihexethyl chloride): dry mouth, blurring of vision, constipation.

Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention.

Also available, without phenobarbital, as PATHILON® Tridihexethyl chloride SEQUELS® 75 mg.

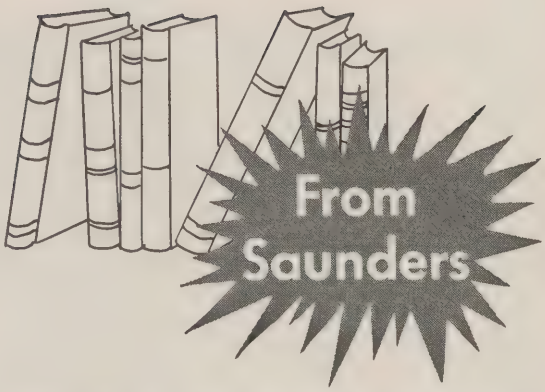
Pathilon® Sequels® with Phenobarbital Sustained Release Capsules

Each capsule contains: Tridihexethyl chloride, 75 mg., and phenobarbital, 45 mg.

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New—Moore's *Give and Take*

The development of tissue transplantation

This is the fascinating story of "new tissues for old"—its relatively brief but eventful history, the present status of the "art," and the promise of the future. Dr. Moore carries you along the devious trail of transplantation progress where you'll follow developments in autografts, homografts and heterografts—observe the intricacies involved in probing antigens, antibodies and immunity—learn of the early organ grafts with no suppression of immune reaction, then of the era of whole body irradiation and its eventual abandonment, and finally of today's successes with immuno-suppressant drugs. The heart of the text deals with the important events and patients in the 250-odd kidney transplants performed in the last decade. Five detailed and exciting case histories delineate turning points in transplantation progress. Intriguing topics, comments and anecdotes crowd the pages of this fascinating book. You'll find such subjects as: *the recognition by the immune system of its own proteins as harmless—the mechanism of immunologic memory—a tale of blood chimerism—the dilemma of tissue and organ donation, both ethical and legal.* Dr. Moore concludes with a succinct discussion of where transplantation is warranted or needed.

By Francis D. Moore, M.D., Mosely Professor of Surgery, Harvard Medical School; Surgeon-in-Chief, Peter Bent Brigham Hospital, Boston, Massachusetts. 182 pages, 5½″ x 8½″, illustrated. About $6.00. *New—Just Ready!*

New (8th) Edition—Nelson's *Textbook of Pediatrics*

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Dr. Nelson and 81 eminent contributors cover the entire field of pediatrics in this *New (8th) Edition.* They discuss every aspect of child care, from the prenatal period through adolescence. They tell you how to keep the well child healthy, as well as how to diagnose and treat the myriad diseases of infancy and childhood. Disorders and malformations of each body system are covered in detail. All the childhood diseases are explicitly described, with authoritative discussions of etiology, epidemiology, pathogenesis, immunity, clinical manifestations, diagnosis, prognosis, prevention and treatment. This up-to-date revision is studded with newly developed diagnostic procedures, as well as both new and standard methods of prevention and treatment. You'll find information on *the problems involved in the battered-child syndrome—on newly discovered inborn errors of metabolism—on new theories of psychologic development.* Many chapters and sections are entirely new—*Pseudomonas and Other Gram-Negative Bacilli—Anonymous Mycobacterial Infections—Intestinal Malabsorption—Waardenburg's Syndrome—Interstitial Pulmonary Fibrosis.* Others are so extensively revised as to constitute virtually new material. Here is a book useful to any physician who ever treats infants or children.

Edited by Waldo E. Nelson, M.D., D.Sc., Professor of Pediatrics, Temple University School of Medicine; Medical Director of St. Christopher's Hospital for Children. With 81 distinguished contributors. About 1640 pages, 7″ x 10″, with 471 figures. About $18.00. *New (8th) Edition—Just Ready!*

New—Elliott's *Clinical Neurology*

Gives specific help on neurologic diagnosis and treatment

Here is a concise new work seasoned with clinical insight. The author skillfully presents crisp accounts of individual neurological diseases (both common and uncommon) plus principles and practice involved in neurological diagnosis. He provides pertinent anatomical, physiological, and neurochemical background material, focusing on practical application. Important diagnostic features of each disease discussed are stressed and the diagnostic significance of individual symptoms and signs are clearly spelled out. Among the many features of this new text you'll find: Helpful information on differential diagnosis of diseases exhibiting such common symptoms as *headache, pain in the face, sciatica, vertigo, coma, seizures, peripheral neuritis, etc.*—Specific treatment outlined in detail—Acute and chronic organic psychoses analysed in terms of neurophysiology. New material brings you up-to-the-minute on: *the reciprocal relationship between brain function and serum electrolytes—the effects of brain lesions on the electrocardiogram—the use of echoencephalography and brain-scanning in diagnosis.* Any physician desiring latest help in diagnosis and treatment of neurological diseases will find *Clinical Neurology* eminently useful.

By Frank A. Elliott, M.D., F.R.C.P., Chief of Neurology, The Pennsylvania Hospital; Professor of Clinical Neurology, University of Pennsylvania School of Medicine. About 672 pages, 6⅜″ x 9¾″, with about 179 illustrations. About $12.00. *New—Just Ready!*

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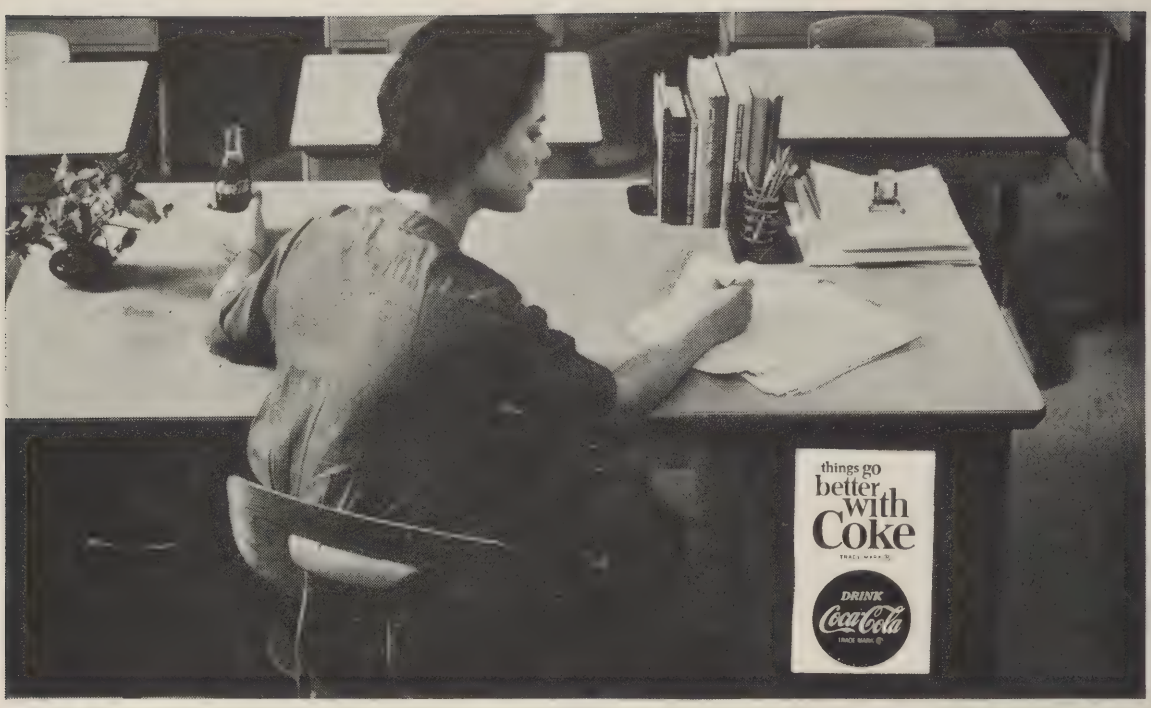
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numbs the pain...not the patient

A potent analgesic and a superior muscle relaxant

1. A sprain or fracture is not a big clinical problem—but it does hurt. And if there is housework to do and kids to mind, the patient needs something to numb the pain.

2. A.P.C. compounds have limited usefulness; and the patient can buy them without your prescription. Unfortunately, most of them are too mild to be effective for sprains—and more potent products too often make the patient feel 'dopey'.

3. 'Soma' Compound is ideal in these cases. Since it contains both 'Soma' (carisoprodol) and acetophenetidin it is both a potent analgesic and a superior muscle relaxant; it also contains caffeine to offset any drowsiness *("numbs the pain... not the patient")*.

4. Why not try 'Soma' Compound? Dosage is 1 or 2 tablets q.i.d. For more severe pain, try 'Soma' Compound + Codeine. Dosage: 1 or 2 tablets q.i.d.

5. Hypersensitivity to carisoprodol may occur rarely. Codeine may produce addiction, nausea, vomiting, constipation or miosis.

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Salt and water retention, edema, overstimulation of the appetite, excessive weight gain, mood swings—these were some of the problems that used to confront physicians when they wanted to prescribe steroids for dermatoses. For patients already overweight, or with edema associated with cardiovascular disease, or those who were tense and anxious, steroid treatment could aggravate their problems. But with the advent of ARISTOCORT® Triamcinolone, many of these patients became "steroid-treatable." The reason: Not only did *this* steroid provide gratifying symptomatic relief, but it did so *without* the penalty of overstimulation of the appetite, excessive weight gain, salt and water retention, edema, and undesirable euphoria. And these benefits have been confirmed for other patients with steroid-susceptible disorders, as well as those formerly untreatable.



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Contraindications: While the only absolute contraindications are tuberculosis, herpes simplex and chicken pox, there are some relative contraindications (peptic ulcer, acute glomerulonephritis, myasthenia gravis, osteoporosis, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, psychic disturbance, pregnancy, infection) to weigh against expected benefits.

A single daily dose may provide effective control, is convenient for the patient, and can be employed in both initial and maintenance therapy.

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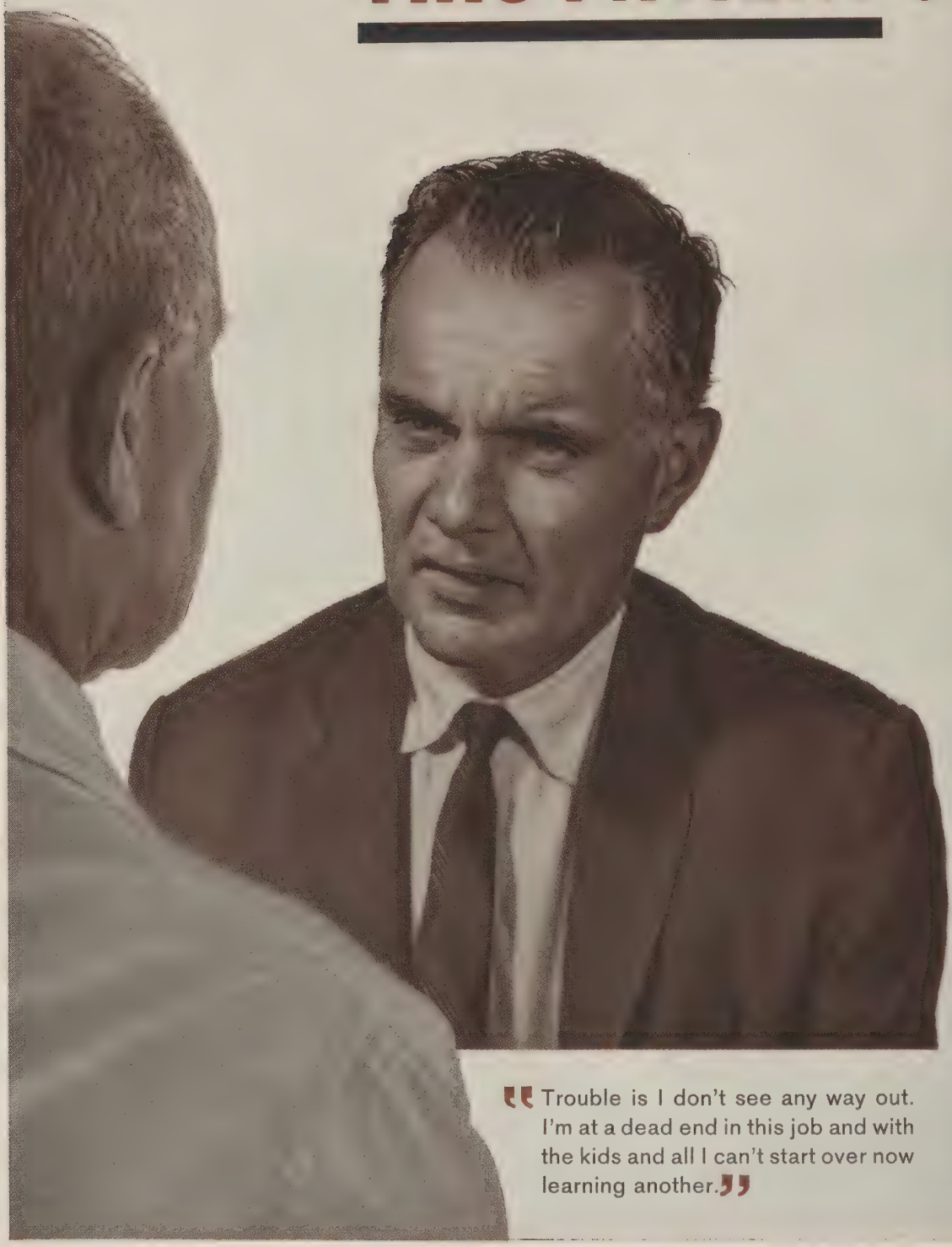
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RECOGNIZE THIS PATIENT?



"Trouble is I don't see any way out. I'm at a dead end in this job and with the kids and all I can't start over now learning another."

When you recognize depression and anxiety traceable to an emotionally charged situation with no somatic disorder

—*start the patient on 'Deprol'*

Typical situations in which 'Deprol' is indicated:

marital or other family problems ■ death of a loved one ■ financial worries ■ fear of cancer, heart disease or other life-threatening illness ■ pre- and post-operative apprehensions ■ retirement problems, and many other stressful situations which cause the patient to feel a sense of loss, guilt or unworthiness

Advantages of 'Deprol'

1. By relieving both depression and anxiety, 'Deprol' lifts the mood of the depressed patient without the agitation and "jitters" that often accompany "energizer" therapy alone.
2. 'Deprol' restores normal sleep, relaxes physical tensions, and improves appetite.
3. 'Deprol' acts rapidly—patients often respond within a week or two.
4. 'Deprol' is relatively nontoxic and free of side effects.
5. When depression and anxiety accompany physical illness, 'Deprol' is compatible with drugs used to treat these organic conditions.

Deprol®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Side effects: Slight drowsiness and, rarely, allergic or idiosyncratic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. **Contraindications:** Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use of meprobamate or meprobamate-containing drugs. **Precautions:** Should administration of meprobamate cause drowsiness, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Although suicides with 'Deprol' have not been reported, prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage of meprobamate may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Even though it has not been reported with 'Deprol', consider the possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available in the product package, and to physicians on request.*

Usual adult dosage: 1 tablet t.i.d. or q.i.d. May be increased gradually, as needed, to 6 tablets daily. With establishment of relief, may be gradually reduced to maintenance levels. **Supplied:** Light-pink, scored tablets Bottles of 50.

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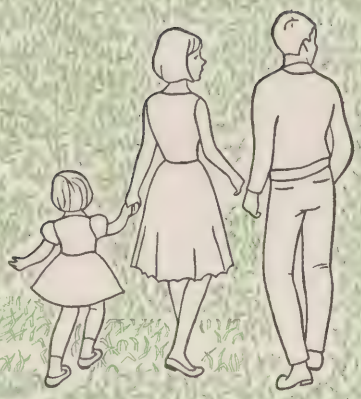
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FOR EFFECTIVE CONTROL OF ALLERGIC SYMPTOMS—*Antihistaminic action* relieves nasal congestion, sneezing, lacrimation, and pruritus. *Antispasmodic action* relieves bronchial spasm. **Precautions:** Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers, if used with BENADRYL (diphenhydramine hydrochloride), should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENADRYL (diphenhydramine hydrochloride). BENADRYL (diphenhydramine hydrochloride) is supplied in several forms including Kapseals containing 50 mg. 39864

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when psychic tension mounts

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useful in alleviating
— psychic tension in the common psychoneuroses
— psychic tension related to situational stress
— psychic tension intensified by concomitant somatic components







ROCHE

How to prescribe Valium (diazepam)

Indications: Valium (diazepam) is of use in dealing with anxiety reactions stemming from stressful circumstances or whenever somatic complaints are concomitants of emotional factors. It is useful in psychoneurotic states manifested by anxiety, tension, fear and fatigue. Valium (diazepam) may also be useful in acute agitation due to alcohol withdrawal. Valium (diazepam) may be of use to alleviate muscle spasm associated with cerebral palsy and athetosis.

Dosage and administration	*Usual daily dose*
Mild to moderate psychoneurotic reactions: Manifested by anxiety-tension alone or with depressive symptomatology, agitation, restlessness, psychophysiological disturbances	2 mg to 5 mg, 2 or 3 times daily
Severe psychoneurotic reactions: Where severe anxiety, fear, agitation, aggression or hostility exist alone or with depressive symptoms	5 mg to 10 mg, 3 or 4 times daily
Alcoholism: As an aid in symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis	10 mg, 3 or 4 times during the first 24 hours; reducing to 5 mg, 3 or 4 times daily as needed
Muscle spasm associated with cerebral palsy or athetosis	2 mg to 10 mg, 3 or 4 times daily

Contraindications: Valium (diazepam) is contraindicated in infants, patients with a history of convulsive disorders or patients with a history of glaucoma.

Warning: Valium (diazepam) is not of value in dealing with psychotic patients manifesting anxiety and should be avoided when there is reason to believe the patient is psychotic.

Precautions: In elderly or debilitated patients, it is important to limit the dosage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, to be increased gradually as needed and tolerated). As is true of all CNS-acting drugs, until the correct maintenance dosage is established, patients receiving Valium (diazepam) should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving an automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam) — particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

Since Valium (diazepam) has a central nervous system depressant effect, patients should be advised against the simultaneous ingestion of alcohol and other central nervous system depressant drugs during Valium (diazepam) therapy. Safe use of Valium (diazepam) during pregnancy has not been established. The usual precautions are indicated when Valium (diazepam) is used in the treatment of anxiety states where there is any evidence of impending depression; particularly the recognition that suicidal tendencies may be present and protective measures may be necessary. The usual precautions in treating patients with impaired renal or hepatic function should be observed.

Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (*e.g.*, convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

Paradoxical reactions, such as excitement, depression, stimulation, sleep disturbances, acute hyperexcited states and hallucinations have been reported. Other side effects noted have been blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash.

Valium (diazepam) is available as 5-mg and 2-mg tablets. For convenience and economy in prescribing, both strengths are supplied in bottles of 50.

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Division of Hoffmann - La Roche Inc / Nutley, N. J. 07110

The Journal of The SOUTH CAROLINA Medical Association

Corticosteroids In Leukemia

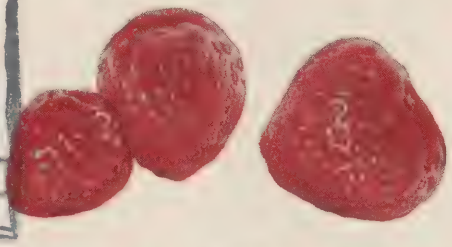
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NTz Nasal Spray also provides decongestive relief for head colds, perennial rhinitis and sinusitis. Supplied in leakproof, pocket-size, squeeze bottles of 20 ml. and in bottles of 30 ml. with dropper.

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NTz is more than a simple vasoconstrictor. It contains Neo-Synephrine® HCl 0.5%—the efficacy of which is unexcelled—to shrink nasal membranes and provide inner space; Thenfadil® HCl 0.1% for topical antiallergic action; and Zephiran® Cl 1:5000 (antibacterial wetting agent) to promote the spread of the decongestant components to less accessible nasal areas.

NTz is well tolerated and does not harm respiratory tissues.

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SEPTEMBER, 1964 — VOL. 60, NO. 9

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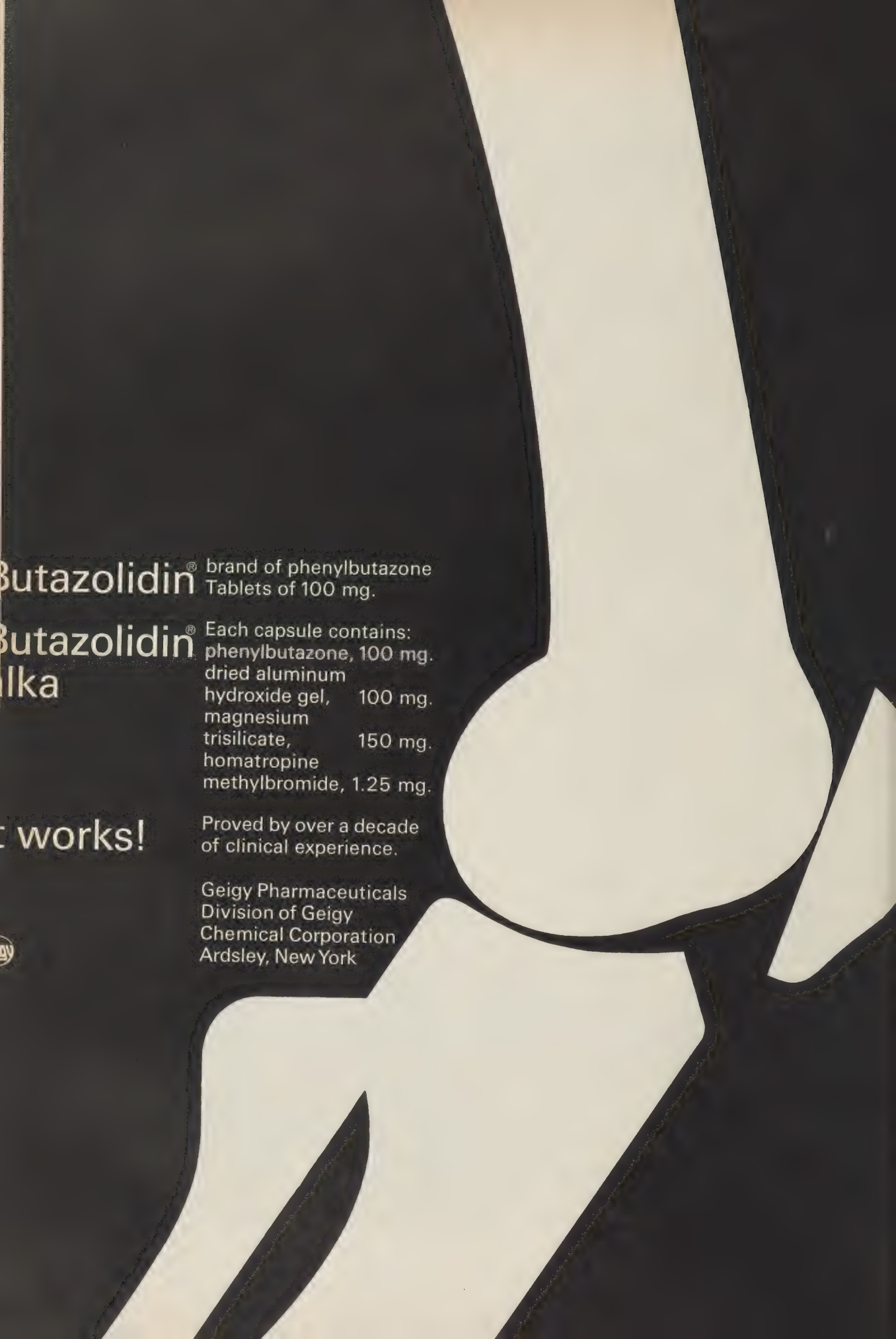
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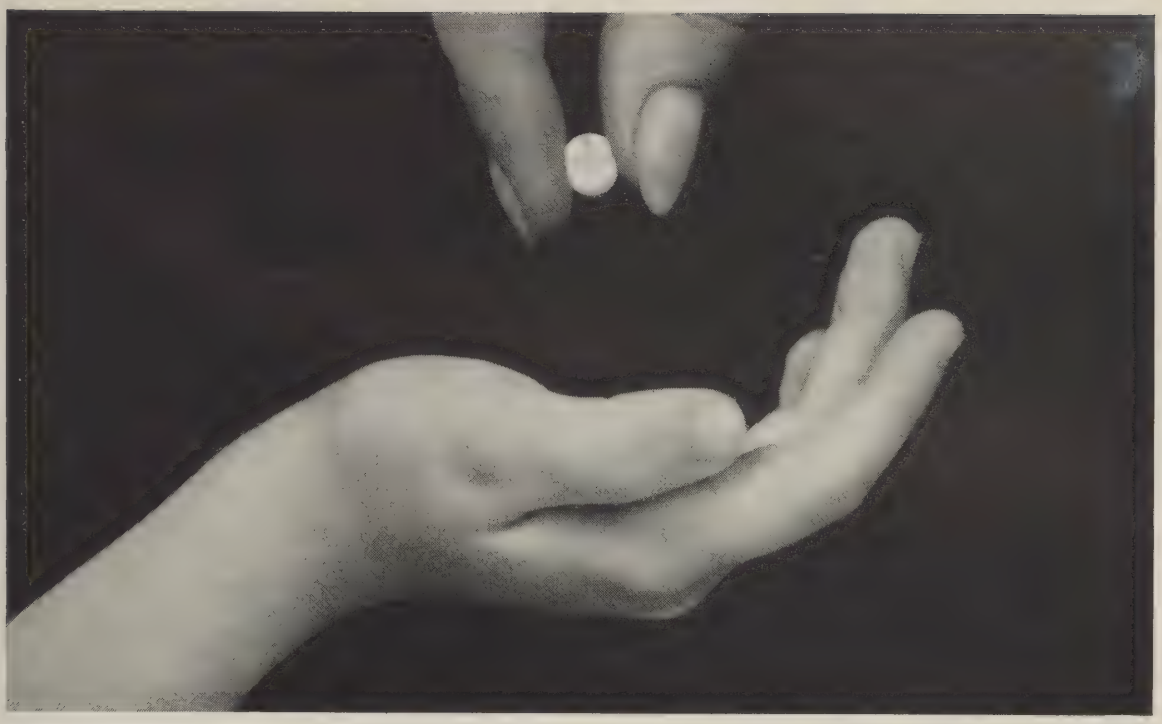
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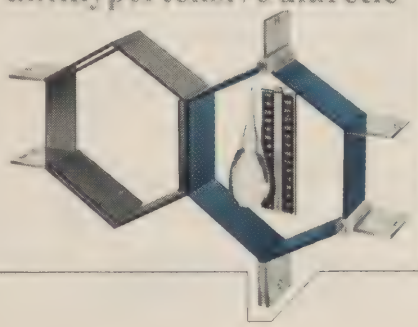
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1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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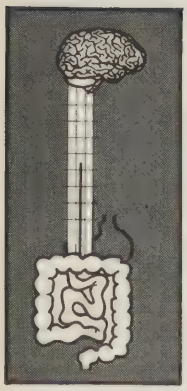
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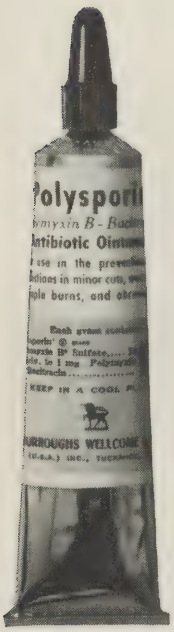
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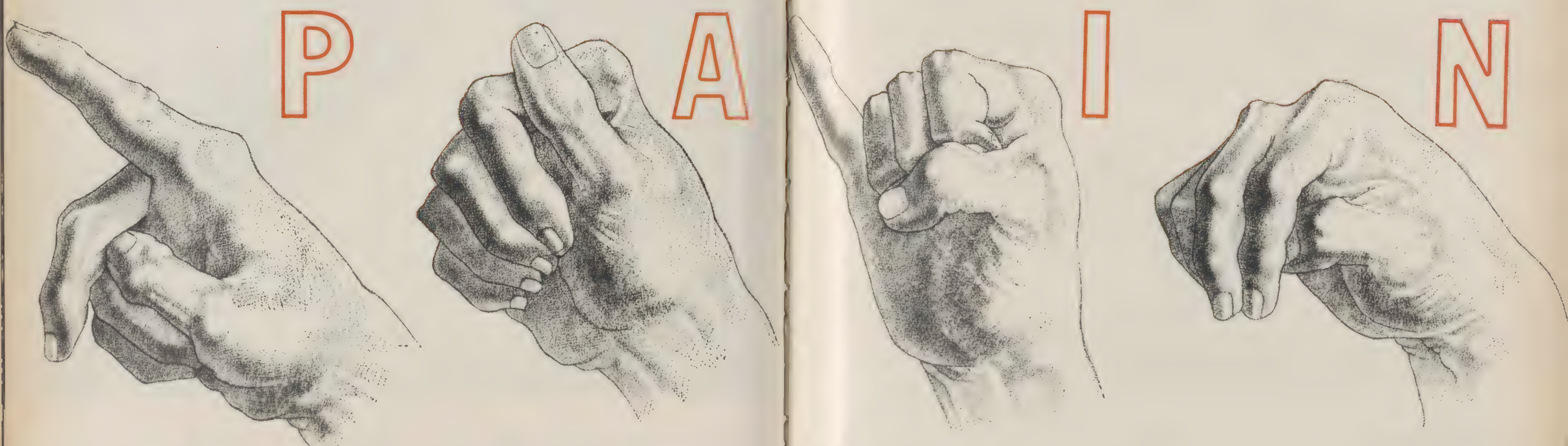
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*Cohen, et al: J.A.M.A., 165:225, 1957.

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CORTICOSTEROIDS IN THE CONTROL OF CHRONIC LYMPHOCYTIC LEUKEMIA

JOHN R. SAMPEY

Furman University, Greenville, South Carolina

In an earlier study corticosteroids showed a remission rate of 85% in 180 patients, which was the highest of any chemotherapeutic agent given in single and multiple drug therapy to patients with chronic lymphocytic leukemia during the decade, 1950-59.[26] Two additional studies on combination therapy with adrenal steroids and other cytostatic drugs showed remission rates of 82% in 40 patients[28] and 92% in another 40 patients from clinical reports which gave sufficient data on the number of cases treated and the number responding.[27] A fourth study on single drug therapy with corticoids registered a 79% remission rate[29] in 69 patients. The present investigation records the results of corticosteroid therapy in single and multiple drug therapy of chronic lymphoid leukemia in clinical reports which have not been cited in earlier studies for the years, 1959-62.

Use of Corticosteroids Alone

Pawelski, and associates, have released three current publications on the use of corticosteroids in the control of chronic lymphocytic leukemia. Pawelski and Wolosewicy[22] reported that nine of 10 patients experienced remissions, following prednisone therapy; the next year[23] they recorded clinical benefit in 22 of 24 patients administered the same steroid, and in 1961[24] Pawelski, *et al*, tabulated remissions ranging from four to 24 months in 12 of 14 patients with aleukemic chronic lymphatic leukemia, following prednisone treatment. Brunner, *et al*,[6] observed some response in all 36 patients who received prednisone, with 13 having remissions for 12 months, and two showing improvement for three years; they also used antibiotics in cases of infection, and they found that gamma globulin reduced the danger of infections. Kyle, *et al*,[15] employed large doses of prednisone and prednisolone to achieve seven good and 13 fair responses in 20 patients; the good remissions were complete or nearly complete for six months, and the side effects included diabetes and infections. Moloney, *et al*,[18] reported that 30 patients responded well clinically and hematologically to corticoids without giving data as to the number. Boiron, *et al*,[4] noted a sharp rise in the white blood cells in four patients out of 16 who received large doses of prednisone, but the effect was temporary and disappeared when the hormone was decreased; few details are recorded on the results. Wainrach[32] observed general improvement in six patients who were given hormones of the gluco-corticoid group, including cortisone, prednisone, etc., and Gorzkowski[14] described similar benefits in four patients on these corticoids and ACTH. Langer[16] treated four patients

with dexamethasone without any benefit, and only one of three patients of Fukase[11] showed hematologic improvement on glucocorticoid therapy. Arnoux[2] described a six months remission in a patient given cortanyl and x-rays. Ruvidic, *et al,*[25] employed the combination hydrocortisone and prednisone to secure a good response in a patient, and Sano[30] induced marked improvement on enlarged lymph nodes with prednisolone in one patient but there was no hematologic benefit. The same steroid, reinforced by two other steroids, resulted in partial clinical and hematologic remission in a patient for 24 months at the time of reporting.[7]

Use of Corticosteroids in Multiple Drug Therapy

Corticosteroids and Nitrogen Mustards. Pawelski, *et al,* included the combination prednisone and chlorambucil in two of their current studies on the management of chronic lymphocytic leukemia: in 1960 they[23] induced good remissions in seven patients, and a year later they[24] chronicled 15 remissions ranging from four to 18 months in 25 patients. Muller[10] reported that seven of eight patients survived more than 12 months on the combination of corticoids and CB1348. Arnoux[2] tabulated three partial remissions for 36, 16 and six months, following the use of cortanyl and CB1348. Revol in a symposium[31] on chronic lymphatic leukemia recommended steroids and CB1348 in cases where there were enlarged spleens. Diamond and Miller[9] maintained a patient for a year on prednisone before changing to CB1348 for six months. Fritzsche and Rietschel[10] employed steroids to reverse the leukopenia brought on by prolonged use of Endoxan in a patient. Nakazima[20] noted only a slight effect of prednisolone and nitrogen mustard oxide in one patient with lymphogenous leukemia following neurological symptoms.

Corticosteroids and Miscellaneous Drugs. Nisnevich and Akopyants[21] combined the antibiotic, Aurantin, with prednisolone to induce partial remissions in all eight cases of chronic lymphatic leukemia. Akkerman, *et al,*[1] treated seven patients with CB1348, four with prednisone, and five with supportive therapy alone: they reported 13 clinical improvements but did not indicate the numbers by the several drugs. Chertkv and Osechenskaia[8] administered steroids and vitamin B_6 in the early stages, but also Myleran and Dopan to secure one remission and eight improvements in 11 cases. Geiro[12] developed general principles and standard therapy in 200 patients: in the early stages he used corticoids; in stage 2 he employed radiotherapy, radiophosphorus, CB1348, or urethan; in stage 3 he added Dipin, thiotriethylene phosphoramide, vitamins or iron to the agents in stage 2; in the 4th and 5th stages he thinks that cytostatic drugs are contraindicated, and he employed only ACTH, corticosteroids and antimetabolite. Brenner[5] noted a long survival in a patient given nitrogen mustard, arsenicals, vitamin and corticoid. Beni and Simonetti[3] narrated a three months remission on prednisone, followed by triethylene melamine; at the time of reporting the patient had been in remission for a year on prednisone with some ACTH administered also. Diamond and Miller[9] had a partial response for 12 months to TEM, and then four months on x-rays, and then four years on prednisone. Arnoux[2] used cortanyl, x-rays and 6-mercaptopurine for a remission of less than a year in one patient. Winkler[33] was able to discharge a patient after clinical and hematologic remission induced by the benzoquinone, Trenimon, and prednisolone. Georhiev[13] described a patient with chronic myelocytic leukemia who developed chronic lymphocytic leukemia after being administered arsenic and cortisone.

Discussion

The 81% remission rate in 115 patients who were administered corticosteroids alone in the present study compares favorably with the 79% in 69 patients noted in an earlier report.[29] The 69% rate in 70 patients who received multiple drug therapy for chronic lymphocytic leukemia is considerably lower than the rates noted in two previous

studies,[27, 28] but this is not surprising since the cytostatic drugs employed in the several studies differ widely in their chemical nature. While corticosteroids do not make the showing reported for the decade, 1950-59,[26] they do give high remission rates in the control of chronic lymphocytic leukemia for the years 1959-62, whether used alone or in multiple drug therapy.

Acknowledgments. The National Library of Medicine and the libraries of Furman University and the Greenville General Hospital made available the original literature.

(A list of references may be obtained from the author.)

Treatment of typhoid carriers with ampicillin—A. B. Christie (Fazakerley Hosp, Liverpool, England). Brit Med J 1:1609 (June 20) 1964.

Eight women patients, typhoid carriers for up to 27 years, who had resisted treatment with chloramphenicol, penicillin, and other drugs were treated with ampicillin, 1 gram three times a day, and probenecid ½ gram twice a day for three months: for the first week ampicillin was also given intramuscularly, 500 mg every six hours. All eight carriers became abruptly negative, and seven remained negative for a year, with up to 100 negative fecal specimens. The eighth carrier responded abruptly, but relapsed twice, each time after being clear for three months. Radiological examination showed normal function of the gallbladder in seven of the eight patients, including the carrier who relapsed.

Fixation of drainage tube to abdominal wall fascia, William H. Prioleau (Charleston). Gynec Obstet 118:1323-1324, June 1964.

Fixation of intra-abdominal drainage tubes is commonly accomplished by some form of suture attachment to the skin. Objections to this method are pain on manipulation, risk of infection with abscess formation, limited holding on account of suture cutting and damage of accidental removal. A preferable method is the use of a loop of nonabsorbable suture material which engages the external layer of fascia and is tied to the tube at skin level. This is free of pain and the risk of skin infection. It is stable and secure for a prolonged period. There is minimal risk of accidental removal of the tube.

Studies show a patient may be his own best donor—G. Milles, H. Langston, and W. Dalessandro (Augustana Hosp, Chicago). Mod Hosp 102:104 (May) 1964.

In 1961, the possibility of obtaining blood from individuals who might require it at a later date was considered. Autologous blood offered certain advantages because it removed the inherent dangers of homologous blood in the form of infectious hepatitis or other transmittable diseases, as well as those of immunization to unidentified antigens and the dangers of mismatching. However, the limitations of autologous blood included the question of venesecting an individual who was scheduled to undergo surgery. It was realized that the patient who could not tolerate venesection of one or even two units of blood was a poor surgical risk. Furthermore, it was known that the one stimulus to blood production and the mobilization of the blood reserves was hemorrhage. Finally, it was felt that the stress of venesection would indeed better prepare the individual for surgery. Based on these principles, the authors expanded the use of autologous blood, and today, more than 200 patients have been venesected of one or more units (500 ml) of blood prior to major surgery. More than half of all the blood they received during surgery and the subsequent 48 hours was their own. Based upon these experiences, the authors' position today is as follows: An individual who is faced with elective surgery, and who might remotely require blood in the course of that operation, is venesected of one unit of blood.

CYTOMEGALIC INCLUSION DISEASE IN INFANTS

NORMAN S. WALSH, M. D.
Charleston, S. C.

Cytomegalic inclusion disease of infants is a rare, generally fatal disease, of viral etiology. The infection in adults is usually of little clinical significance. Opportunity was recently afforded to study such a case in this laboratory and one additional case found in its collection. In answer to a questionnaire to pathologists in this state, one case each was reported from Florence, Greenville, and Greenwood.

Because of the rarity and the possibility of increasing interest in inclusion disease, two cases are added to the record.

Case Reports

Case I: S. D., a 14-day old colored male, was delivered uneventfully on November 29, 1963, of a 17-year old primigravida, at home, by a midwife, after a normal pregnancy. Birth weight was 7½ pounds. He did well until age 9 days when bright red rectal bleeding was observed. At age 13 days, bleeding occurred at the umbilicus. The referring physician noted jaundice and a hemoglobin of 13 grams. The urine was never dark, and the stools were green. The family history was non-contributory.

The admitting physical examination was not remarkable except for intense jaundice. Laboratory data was as follows: Hemoglobin 13 Gm/100 ml, platelets 82,000, WBC 10,000. The urine was positive for bile, and negative for urobilinogen. Stool was positive for blood by guaiac test. Serum albumin was 3.17 Gm/100 ml; serum bilirubin was 34.0, 24.2 of which was direct. Coomb's test was negative. Prothrombin activity was 22%; E. coli was over 300,000 bacteria per milliliter of urine. The mother and child were blood type 0 positive. One examination of urine for inclusion cells was negative. Bilirubin rose to 38.6 mg/100 ml on the day following admission, and temperature rose to 102°. The patient developed hepatosplenomegaly and became markedly irritable. A lumbar puncture revealed 4,160 WBC per high power field; and the smear was loaded with gram positive cocci. He was placed on antibiotics but died shortly thereafter. Brain films postmortem were negative for intracranial calcification.

At autopsy, pus was found in the left middle cranial fossa, and a 0.5 cm area of calcification was found in the subependymal region of the right lateral ventricle. The liver was three times the normal weight, and the spleen was twice the normal weight. Microscopically, there was generalized inflammation and giant cell formation in the liver with the presence of numerous inclusion bodies in the epithelial cells of the bile ducts. Inclusion cells were prominent in the proximal convoluted tubules of the kidneys. They were also found in the lung, thymus, and pancreas.

Case II: J. F., a 10-month old white male was delivered spontaneously in October, 1959, following a normal pregnancy. Birth weight was 8 pounds, 3 ounces. A brother, age four, is normal; another sibling died at age 10 months of pneumonia. At age 2 weeks this child was noted to have jaundice and a heart murmur. He had generalized seizures at age 3 months, 5 months, and 6 months. He was referred here for evaluation after he had gained only three pounds above his birth weight and was unable to sit without assistance. For two months prior to admission, he had been having six to eight greenish, watery stools per day. On admission, x-rays revealed a bone age of three months. There were no intracerebral calcifications. The electroencephalogram was reported as abnormal. A lumbar puncture revealed normal findings. Encysted Endameba histolytica was found in the stool. He was started on Diodoquin (diiodohydroxyquin) but pursued a progressive downhill course to death, with no one clinical cause predominating. Jaundice was not present during this admission. He was Rh positive and his mother, Rh negative. The clinical diagnoses were erythroblastosis fetalis, amebiasis, and interventricular septal defect.

At autopsy, cytomegalic inclusions were found in the lung, liver, kidney, adrenals, pancreas, spleen, stomach, small bowel, colon, anterior pituitary, and cerebrum.

From The Department of Pathology, Medical College of South Carolina, Charleston, South Carolina.

Discussion

A. *Etiology*

Cytomegalic inclusions were first described in 1904 by Jesionek and Kiolemenoglou.[5] Ribbert[8] reported three cases that same year and remarked that in 1881 he had noted inclusions in the kidneys of a newborn infant. The first observers of inclusions believed that they were a stage of protozoal infection. The term "cytomegalia" was suggested by Goodpasture[4] in 1921 when he noted the presence of inclusions in the organs of a child who died of pneumonia. He also cited the resemblance between human cytomegalic cells and the cells of salivary gland virus disease of guinea pigs. In 1906 Tyzzer[12] described intranuclear bodies in the organs of persons who had varicella. Farber and Wollach[2] found inclusions in the salivary glands of twenty-two infants. Two had congenital syphilis; two died of hemolytic disease of the newborn; and one had measles. Cappell and McFarlane,[1] in 1947, reported two cases of death due to hemolytic disease of the newborn and observed widespread intranuclear inclusions. They compared the anatomical similarity between these cells and those found in rodents with salivary gland virus disease. This was the first suggestion of a viral etiology of CID. Reporting six cases of CID in 1950, Wyatt[15] concluded that the cause was a specific virus and that the microscopic findings were pathognomonic of the disease. In 1954, Smith[10] cultured the salivary gland virus of mice and transmitted the disease by inoculation. Two years later,[11] she isolated a virus from two infants and noted inclusion formation in cultures on human fibroblasts. The following year, Welles[13] recovered a virus from the urines of two patients with non-fatal CID and from liver tissue of another. At present, culturing the virus from infected patients has little clinical value.

B. *Clinical Findings*

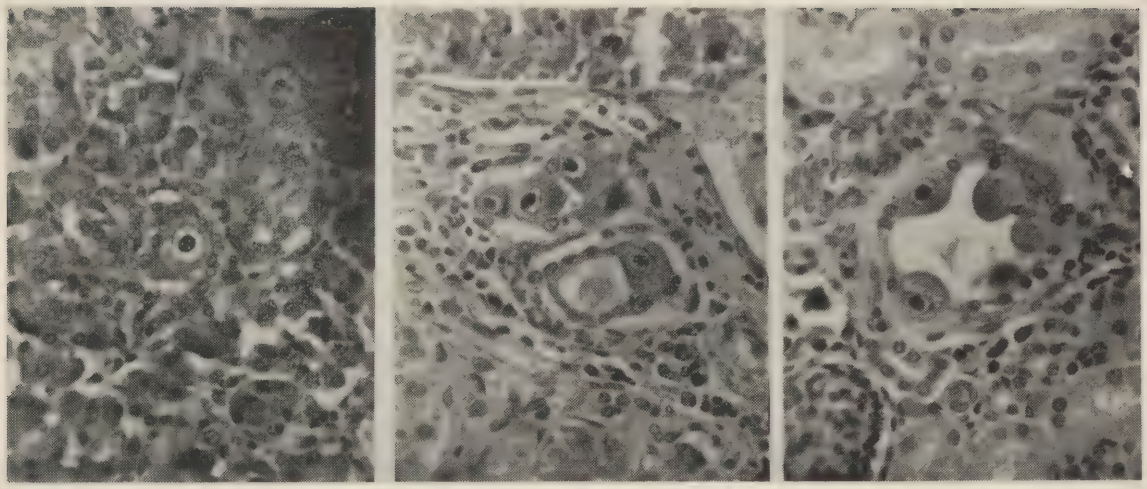
Potter[7] noted four forms of infection with the salivary gland virus: (a) infection of adults with absence of symptoms and probably the limitation of pathologic changes to the salivary glands; (b) infection of children or adults with spread to lungs or intestine in the presence of debilitating disease from other causes; (c) infection in infancy or early childhood with involvement of lungs or intestine; (d) infection of the fetus with production of a generalized fatal disease.

A typical case in infants may have all or several of the following manifestations of the disease: immaturity or prematurity, bleeding from the umbilicus with petechiae and jaundice at birth or within several days thereafter, microcephaly, chorioretinitis, hepatosplenomegaly, anemia, and periventricular calcification of the brain. Death is frequently due to secondary infection, such as pneumonia and meningitis.

C. *Pathology*

At autopsy, intranuclear inclusions have been found in virtually every organ and tissue in the body. In noting the findings from 132 cases of CID, inclusions were found in the kidney in 92, lung in 78, liver in 42, pancreas in 24, thyroid in 20, and in other organs less frequently. The salivary gland is rarely involved in generalized CID.[7] The incidence of inclusion cells found in one or more organs of infants during routine autopsies is said to be 1 to 2%.[2]

The inclusion cell has the same appearance wherever it is found (Fig. (a), (b), (c)). In the kidney, the cells of the proximal convoluted tubules are the most frequently involved and the tendency for the affected cell to desquamate is the basis for the findings in the urine. In other organs, there is about equal involvement between the epithelium and parenchyma. The cell diameter varies from 10 to 40 microns. The cytoplasm stains basophilic and may contain small acidophilic granules. It may either completely surround the nucleus or lie in an eccentric position. The nucleus exists as a sphere which when sectioned is a thin circle or oval enclosing the characteristic clear zone or halo. At low magnification the deeply staining inclusion body has a solid appearance. At magnifications above 1000 X, however, it is seen to be composed of smaller, irregular, solid structures. Giant cell formation is not unusual;



(a) This photograph of pancreas illustrates the dark central inclusion body, the clear zone, the thin nucleus around it, and the cytoplasm.

(b) Epithelial cells of two small bile ducts.

(c) A proximal convoluted tubule with typical inclusions of the epithelial cells.

however, the inclusion cell is not incorporated in the giant cell. In view of our present knowledge and experience, the previously described cell is pathonomonic of CID.

D. *Diagnosis*:

Before 1952 the diagnosis of CID was made only at post-mortem examination. In that year, Fetterman,[3] at the suggestion of Wyatt,[15] found inclusion cells in the urine sediment of a two-day old infant who died at age 4 days. The inclusion cells can be observed in a smear of unstained urine sediment. It is quite important that the urine be fresh or refrigerated. A false negative diagnosis becomes more frequent in the presence of a concomitant urinary tract infection. At least three fresh morning specimens should be examined before assuming the urine to be negative. A more refined technique of examining the urine is described by Naib.[6]

The writer is not aware of any cases in which the diagnosis was made from examination of the stool; however, after noting the widespread involvement of the colon mucosa in Case II, it is suggested that when CID is suspected, a search be made in the stool as well as in the urine for inclusion cells. It is conceivable that CID cells could be mistaken for amebic cysts.

Skull films may show calcifications around the lateral ventricles in which case toxoplasmosis must also be considered.

First to be considered in the jaundiced infant is erythroblastosis fetalis and ABO incompatibility which can be excluded by the Coombs test and by blood typing. Toxoplasmosis is ruled out by a negative Sabin-Feldeman dye test.[9] Also capable of producing a similar clinical picture are generalized syphilis, sepsis, biliary atresia, congenital hemolytic jaundice, hereditary nonspherocytic hemolytic anemia, and leukemia.

E. *Treatment*:

There is no specific treatment for CID; however, the routine use of cortisone has been moderately successful. Exchange transfusion is indicated as in any other situation causing elevation of the bilirubin above the generally accepted value of 20 mg/100 ml.

F. *Conclusion*:

Cytomegalic inclusion disease may be the cause of infant deaths in some cases previously attributed to jaundice of undetermined etiology. This disease in infants remains generally fatal. The diagnosis can be confirmed by the findings of the typical inclusion cells in urine sediments. An additional

diagnostic procedure is proposed, but as yet no known cases of CID have been confirmed by stool examination. There is no specific therapy, but cortisone is useful.

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A study of T wave changes in the electrocardiograms of normal individuals—C. E. Kiessling, R. S. Schaff, and A. M. Lyle. Amer J. Cardiol 13:598 (May) 1964.

When reviewing applicants for life insurance the question arises as to how one should evaluate those who show T wave changes but who are otherwise normal as far as can be determined. A minor T wave change was considered to be one that is relatively low when compared to the amplitude of the QRS complex. Any T wave that was more abnormal than the minor group was considered major. The authors reviewed the electrocardiograms of approximately 11,000 individuals and found only 46 cases classified as major T wave changes with no other evidence of disease; the figure was so small that it was not worth considering. The minor T wave group, 422, was compared with the control group, 1,805, using three factors of measurement: (1) mortality ratio; (2) the percentage dying from coronary occlusion; and (3) the per cent of the total number subsequently developing a coronary occlusion. The mortality figures and the group showing minor T wave changes show an increased percentage of men dying of coronary disease and an increased percentage developing coronary occlusion though still living at the end of the observation period. Among insurance applicants or any other group, cases showing T wave changes may harbor some old occlusions, silent or so atypical that clinical diagnosis was never made.

New method of treatment of ganglions and synovial cysts—L. Dao (Apartado 1429, Caracas, Venezuela) J Occup Med 6:217 (May) 1964.

A new transfixion method was used in the treatment of 252 ganglions, 9 knee synovial cysts, and 7 elbow synovial cysts. Of the total of 268 cases, 49 ganglions had been previously treated surgically, and had recurrence. The method consists of the local anesthesia of the immediate periphery of the ganglion or cyst, and the transfixion is made through the anesthetized areas with a thick cutting needle threaded with a chromic catgut or cotton thread. The suture is looped around and over the ganglion and tied in a knot. The suture is pulled back and forth daily to keep the orifices open. Slight pressure is applied on the ganglion to induce drainage of the liquid. After eight to ten days, the ganglion is empty and the thread can be removed. In case that the contents of the ganglion is fluid and nonviscous it can be extracted by suction by means of a large hypodermic needle. Complete cure was obtained in 266 of the cases so treated, including the 49 cases that previously had recurrence. The follow-up examination of several cases, after a period of 10 to 12 years, showed that there were no recurrences.

President's Page



How often do we have a patient come into the office for examination and we find they have had a previous injury or operation. We ask the question: "What was the matter with you." or "What operation did you have?" The patient answers, "I don't know, the doctor didn't tell me."

Frequently a mother brings her child into the office with a nail in his foot or some other dirty wound and the question of administration of tetanus toxoid arises: "Has your child had the tetanus toxoid?" you ask. "Oh! Goodness me." is the reply. "He had some kind of shots. I don't know what kind."

In the first instance, the knowledge of what was removed and what is remaining might be the difference between surgery and conservative medical treatment. In the second instance, there is the real difference of risking reaction to tetanus antitoxin or risking a tetanus toxoid booster on the chance that the "shots" were tetanus toxoid.

There might be occasions where it is inadvisable to tell the patient what was done to them; it is difficult to think of one. Of course there are patients who don't listen and some who don't understand, but I believe it is incumbent upon the doctor to make it as clear as possible just what the condition was and what was done.

In the case of the "unknown shots," we have a situation which faces the entire medical profession and the public at large. No matter how many "cards" we give to the patients, they seem to have a way of losing them. In the case of the tetanus toxoid, I hope we can find a way for mass vaccination. Insofar as the record of vaccinations and inoculation is concerned, it appears that education as to the importance of an accurate record is the proper approach. Many of us remember the shot after shot we gave the GIs when they could not show that they had previously had their required ones. Let us hope that this will not be the case with the civilian youngsters.

Frank C. Owens, M. D.

Editorials

Twenty-Five Years of Blue Shield

We congratulate Blue Shield on its 25th anniversary!

A short 25 years ago, many Americans hit by serious illness faced medical bills which mortgaged their earning for years to come. A method was desperately needed to insure them against the high cost of unexpected medical care. At that time insurance companies were approached by the medical profession and asked to provide health insurance protection. Doctors were told that underwriting such protection was not feasible.

The medical profession, recognizing its responsibility to the community, had to devise some way to ease the financial and emotional burden of medical expenses upon those who became ill. In 1939, the California Medical Association took the lead by formulating the first Blue Shield type plan which enabled members to prepay their medical expenses on a community-wide basis.

In 1948, necessary enabling legislation was passed by the General Assembly of South Carolina permitting the establishment of nonprofit medical care plans. On April 1, 1950, Blue Shield coverage was made available for the first time in South Carolina.

In the early years, the insurance companies' warning that health insurance underwriting was not feasible seemed all too realistic. Too many dollars were paid out in proportion to income received. By trial and error, physician-trustees and administrators of early Blue Shield plans were able to put plans on the sound actuarial basis that exists today.

The phenomenal quarter century national growth of Blue Shield to 83 autonomous plans, with over 53 million members receiving better than a billion dollars in benefits in 1963, proves that Americans given the opportunity prefer to prepay their medical-surgical expenses voluntarily.

The year 1963 was the 15th year of operation for the South Carolina Medical Care Plan. With the total Blue Shield enrollment reaching 251,000 members. Blue Shield paid 75,000 claims totaling $2,808,277.04 in benefits.

On its 25th anniversary, with only the slightest pause to look back with pride on its 25 year success story, Blue Shield girds for the challenges ahead. The challenges are great.

Striking advances in medical science are continually pushing the cost of medical care to record highs. Blue Shield coverage seeks to encompass the latest medical innovations without pricing Blue Shield out of the range of the low income groups and other disadvantaged segments of the population.

President Johnson's administration, in continuing to seek passage of the King-Anderson Bill (Medicare) through a Senate amendment this session, is attempting to discredit the health care prepayment plans by ignoring the progress made by Blue Shield and other voluntary health care plans in providing health care protection.

Thus, the two of the major challenges which lie ahead for Blue Shield are those of continuing to provide an equitable, actuarially sound income-benefit relationship, while showing that government intrusion into the health care field is unnecessary.

Actually, these are problems Blue Shield has faced for the past 25 years. Though the problems are greatly intensified now, Blue Shield's past record gives every indication that they will be successfully met in the years to come.

Robert Tomlin

An Early Carolina Researcher

In the editorial section of the JAMA of July 27, 1964, page 319, appears an account of Stubbins Ffirth, M. D. In the course of an interesting career, Ffirth experimented boldly on himself by ingesting or applying materials

from patients with yellow fever, proving that the disease was not transmissable by the methods he used.

Ffirth was a practitioner in the best tradition. The inscription on his tombstone reads: "Sacred/ to the memory of/ Stubbins Ffirth, M. D./ Who departed this life at Ffirthville, St. Paul's Parish, S. C./ on the Fourth of July, 1820/ in the 39th year of his age/ As a husband and father, he was/ kind and affectionate, as a/ Master, he was just and indulgent/ As a friend he was sincere/ And true; as a physician/ he was eminent in his profession/ Had an extensive practice/ Was prompt and ready at every call/ whether proceeding from the poor/ or the rich, as Thousands/ Can testify/ As a Christian he was devout/ And at the same time liberal in his opinions."

Until recently this stone was to be seen near the ruined church tower at Dorchester, some twenty miles from Charleston. Then the stone was broken into three parts, probably by vandals, and now two of the three pieces have disappeared. The largest portion remains.

It seems a pity that this marker to a distinguished physician should be lost. The editor of this Journal has undertaken to solicit contributions toward the restoration of the stone, and has already received some donations. It is hoped that readers might see fit to help in the plan to honor again a worthy member of the profession.

Any small sum will be welcomed.

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Dr. William C. Cantey	Columbia
Dr. James B. Young	Anderson
Dr. Harry Mays	Fair Play
Dr. J. K. Owens	Bennettsville
Dr. Rufus K. Nimmons, Jr.	Seneca
Dr. Murray T. Jackson	Conway
Dr. Donald G. Kilgore	Greenville
Dr. John K. Webb	Greenville

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Dr. R. G. Latimer	Cayce
Dr. Henry C. Robertson, Jr.	Charleston
Dr. Ripon W. LaRoche	Camden
Dr. James L. Wells	Orangeburg
Dr. J. Anthony White	Easley
Dr. Michael Holmes	Kingstree
Dr. Francis P. Owings	Union
Dr. Robert S. Clarke, Jr.	Due West

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Dr. Orlando B. Mayer	Columbia
Dr. Margaret Q. Jenkins	Charleston
Dr. Geo. R. Dawson, Jr.	Florence
Dr. R. Murdoch Walker	Sumter
Dr. James R. Reid	Fort Mill

News

Dr. Metropol In Columbia

Dr. Harry Jack Metropol, a native of Manning, has opened an office for the practice of general surgery and chest surgery in Columbia at 1609 Brabham Street.

A diplomate of the American Board of Surgery, Dr. Metropol served two years in the U. S. Army Medical Corps from 1957-59 as a captain.

He received the A. B. degree from Duke University in 1953, graduating magna cum laude and as a member of Phi Beta Kappa.

He completed studies at the Duke University Medical School in 1956 and was a member of Alpha Omega Alpha honorary fraternity. He then served a one year surgical internship at the Albany Medical Center Hospital, Albany, N. Y.

He recently completed five years residency in general and thoracic surgery at North Carolina Baptist Hospital and The Bowman Gray School of Medicine.

Dr. Robert Jackson Gets Award

Dr. Robert E. Jackson of Manning, 1964 Heart Fund chairman for Clarendon County, was presented with a service recognition award by the South Carolina Heart Association in a brief ceremony on June 30.

Dr. Harris To Practice Surgery

Dr. Robert Miller Harris, Jr. has recently moved to Hartsville to become a partner with Dr. P. K. Moyd in the practice of general surgery.

Dr. Harris, a native of Lewisburg, West Virginia, was graduated from Johns Hopkins University. He received a Bachelor of Science in medicine from West Virigina University Medical School and his Doctor of Medicine Degree from the Medical College of Virginia. He was elected to Alpha Omega Alpha, national medical honorary scholastic society, and to Sigma Zeta, national professional honorary society. He is also a member of Phi Beta Pi, medical fraternity.

He served his surgical internship and residency at the Medical College of Virginia Hospitals. As resident he completed his chest and heart surgery training at McGuire Veterans Hospital. He received special training at Sheltering Arms Hospital, St. Philip Hospital and the Medical College of Virginia Hospital. He completed advanced training in vascular surgery at the Medical College of Virginia and at McGuire Veterans Hospital.

Dr. Harris furthered his surgical training with research in the hemodynamics of the liver at Brown-Sequard Surgical Research Laboratories. Other research was carried out in the field of kidney transplantation and his findings have been published in medical literature.

Dr. Fairey Honored

Dr. Thomas Keller Fairey of Johnston, health officer for Edgefield and Saluda counties, has been honored by the South Carolina Health Department in recognition of services rendered the two counties over a 25-year period.

Dr. Fairey, a graduate of Wofford College and South Carolina Medical College, came to Johnston in 1923. He is a member of Johnston Methodist Church and has served as treasurer of Edgefield County Charity Hospital Fund since its organization 15 years ago.

Dr. Fitzgibbons Opens Offices In Columbia

Dr. Rodney Fitzgibbons, formally with the USA Hospital at Fort Jackson, has begun private practice in Columbia.

He specializes in obstetrics and gynecology.

He has been at Fort Jackson for the past four years. While there he was a major in the Medical Corps serving as chief of the OB-GYN Section of the hospital and as assistant chief of surgery. He is a Board certified specialist and is a Fellow of the American College of Obstetrics and Gynecology. He attended the University of Arkansas Medical College from 1957-1960.

Dr. Parkinson At York

Dr. Thomas Parkinson assumed his duties as anesthesiologist at York General Hospital August 1.

Dr. Parkinson completed his residency in anesthesiology at the Medical College of South Carolina in June.

He is a native of Yorkshire, England, and received his medical degree from Durham University, England. He has been in the United States for 10 years, working at the state hospital in Morganton, N. C. and as a general practitioner in Gastonia, N. C.

Dr. Henry Kuemmerer Will Practice At Westminster

Dr. Henry Kuemmerer, a native of Walhalla, is scheduled to begin practice at the Westminster Medical Clinic in October.

Dr. Kuemmerer is a graduate of the class of '56 at Clemson College. He graduated from the Medical College of South Carolina in 1963 and completed his internship at Greenville General Hospital in 1964.

Mental Illness and Health Congress

The Second National Congress on Mental Illness and Health, sponsored by the Council on Mental Health is on November 5-7 in Chicago. Information is available from the Council, c/o AMA, 535 N. Dearborn, Chicago, Ill. 60610.

New Surgeon Locates In Aiken

Dr. Guy C. Heyl, Jr. has opened an office in Aiken to practice orthopedic surgery. A graduate of the University of Virginia, Dr. Heyl also attended the Medical College in Augusta. He holds B. A. and M. D. degrees from the University of Virginia.

Born in Warrenton, Va., Dr. Heyl served four years in the United States Air Force. He also served in Herscher, Ill. as a general practitioner from 1958 until 1961.

The American College Of Physicians Postgraduate Course

COURSE NO. 3
THE PHYSIOLOGICAL BASIS
OF INTERNAL MEDICINE
October 12-16, 1964

Duke University Medical Center, Durham, Eugene A. Stead, Jr., M. D., Director; Elbert L. Persons, M. D., Co-Director.

This course will deal with recent progress in understanding, diagnosis and treatment of disease in the major areas of internal medicine. Emphasis will be placed on the physiological mechanisms underlying the disease processes.

Carolina Nursing Home

Groundbreaking has started for the new nursing and convalescent center to be located at 341 Calhoun Street, Charleston. The 102-bed facility is scheduled for completion in March, 1965.

Doctors To Head Blood Program

Dr. Pickens Moyd and Dr. Robert Harris will serve as co-chairmen of the Hartsville Red Cross Chapter's Blood Program for 1964-65.

Dr. Moyd and Dr. Harris, who are practicing surgeons in Hartsville, will be organizing their committees in order to meet the Hartsville Red Cross Chapter's blood quota for the year of 1,100 pints of blood.

Doctors On Bowman Gray Hospital Staff

Dr. Conan M. Roberts of Latta, and Dr. Jack M. Smith of Florence, have been appointed to the house staff of North Carolina Baptist Hospital and the Bowman Gray School of Medicine.

Roberts, who has maintained a general practice in Latta since 1954, is taking residency training in psychiatry. Smith began a residency in surgery August 15.

Roberts holds the B. S. degree from Wake Forest College and the M. D. degree from the Bowman Gray School of Medicine. He served an internship and took one year of residency training in internal medicine at Roper Hospital in Charleston.

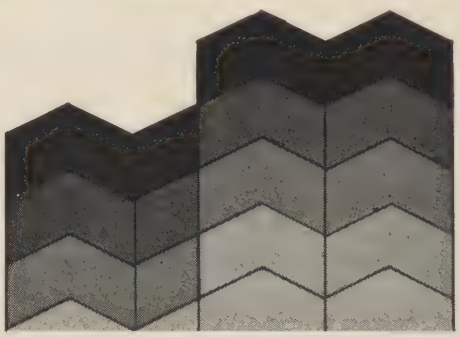
Smith, a 1957 graduate of Wofford College, received the M. D. degree from the Medical College of South Carolina where he also took internship training. For the past two years he has been a staff surgeon for the U. S. Army Weapons Command, Rock Island Arsenal, Ill.

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of all oral corticosteroids:

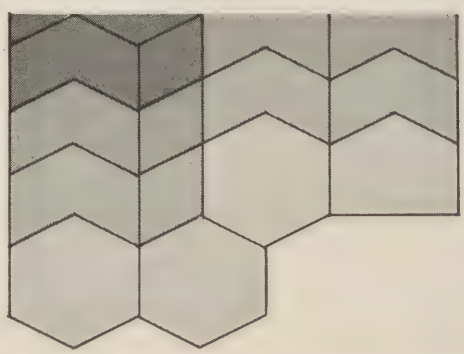


one of the most
powerful antirheumatic
glucocorticoids yet
synthesized[1]



among the highest on the activity spectrum
among the lowest on the cost spectrum

priced substantially
lower than the majority
of analogous compounds



Dr. Logue Moves To North Augusta

Harry Edward Logue, M. D. has opened offices in North Augusta.

He is associated with Dr. Carl Shealy at 325 Georgia Avenue.

A native of Tennille, Georgia, Dr. Logue received his pre-medical education at Emory University where he graduated in 1958. He entered the Medical College of Georgia and received his M. D. degree in 1963. His internship was completed at University Hospital in Augusta.

Dr. J. M. Brice Opens Office In Lancaster

Dr. J. M. Brice of Rock Hill has announced the opening of an office in Lancaster for the practice of orthopedic surgery.

Dr. Brice is a member of the medical staff of Marion Sims Memorial Hospital in Lancaster.

Association of American Physicians and Surgeons

21st Annual Meeting
New Orleans October 8, 9, 10, 1964
The Roosevelt Hotel

Mound Park Hospital Foundation, Inc.

Symposium on Modern Concepts of Nutrition and Heart Disease. American Medical Association, Mound Park Hospital Foundation, Department of Medical Education of the Mound Park Hospital, Medical and Research Divisions of Bay Pines V. A. Center, Pinellas County Medical Society, American Academy of General Practice—October 22 to 24, 1964, inclusive. The Foundation reserves the right to limit registration. Fee $15.00 (by special arrangement). 18 Credit Hours Category 1 allowed. Address NUTRITION, Mound Park Hospital Foundation, Inc., St. Petersburg, Florida, 33701.

Medical College of Georgia Continuing Education Courses

1964-1965

Psychosomatic Medicine Conferences
October 7—December 23, 1964

12 weekly sessions—Wednesday Evenings from 7:30 - 9:00 P. M.

Muscular Skeletal Problems in Children
November 10 - 12, 1964

Electrocardiography
January 19 - 21, 1965

Concepts of Fetal and Maternal Welfare
March 2 - 3, 1965

Problems in Gastroenterology
March 31 - April 2, 1965

Seminar on Chronic Pulmonary Disease
May 1 - 2, 1965

Co-sponsored with Georgia Thoracic Society and the Georgia Tuberculosis Association.

DEXAMETH (dexamethasone) exerts a prompt and potent ameliorating effect in patients with rheumatoid arthritis[2]; symptoms of inflammatory reaction are quickly suppressed in a substantial proportion of patients, joint stiffness is relieved and function improved.

DEXAMETH (dexamethasone) is less likely than some of the older steroids to produce electrolyte imbalance, hypertension, and disturbance in carbohydrate metabolism. Abnormal weight gain may limit the usefulness of the drug in some patients, but may be advantageous in others.

PRECAUTIONS: At therapeutic dose levels, DEXAMETH (dexamethasone) may have less tendency to cause sodium or water retention, potassium excretion, disturbance in glucose metabolism or hypertension than some of the older steroids. With these exceptions, however, the drug may give rise to the metabolic and hormonal side effects characteristic of corticosteroids. It should, therefore, be used with great caution in the presence of tuberculosis and other infections, osteoporosis, peptic ulcer, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, herpes simplex, psychotic tendency, pregnancy and in persons exposed to chickenpox, measles or scarlet fever.

CONTRAINDICATIONS: Ocular herpes simplex, arthritis complicated by psoriasis, tuberculosis of the eye and skin, fungal keratitis, and local pyogenic infection.

Before prescribing, consult product brochure.

DEXAMETH®
BRAND OF DEXAMETHASONE
TABLETS 0.75 mg. and 0.5 mg.

Dosage: In rheumatoid arthritis, the initial daily dosage ranges from 1.5 to 3.0 mg. The dosage is then decreased gradually to the minimum that will maintain sufficient relief; this may be as little as 0.75 mg. per day. After extended therapy, it is especially important that the drug be withdrawn gradually to allow recovery of normal adrenal function.

1. Ringler, I., West, K., Dulin, W. E. and Boland, E. W.: Metabolism 13:37, 1964.
2. Black, R. L., et al.: Arthritis and Rheumatism 3:112 (April) 1960.

U.S. VITAMIN & PHARMACEUTICAL CORPORATION • 800 SECOND AVENUE, NEW YORK, N.Y. 10017



Photo by E. S. Powell, State Board of Health

State Board Of Health

Ground was broken July 2 for the new State Board of Health administrative building and laboratory located on Bull Street Extension north of Confederate Avenue in Columbia.

Governor Donald S. Russell lifted the first shovel of dirt to initiate construction of the modern four-story building. Other officials participating in the ceremonial spadework included Dr. W. R. Wallace of Chester, Chairman of the Executive Committee of the State Board of Health, Dr. Frank C. Owens, Vice-Chairman of the Executive Committee and President of the S. C. Medical Association, Dr. G. S. T. Peeples, State Health Officer, Dr. William S. Hall, Director of the State Department of Mental Health, and Walter B. Brown, State Sinking Funds and Property Director.

The structure, approved by the 1962 General Assembly, will cost an estimated $2,450,000, with the federal government putting up $1.1 million of the total from Hill-Burton funds.

Scheduled for completion in late 1965, the dual purpose building will house all divisions of the State Board of Health and also the S. C. Water Pollution Control Authority which now occupy one and a half floors of the Wade Hampton State Office Building plus six other rented office facilities in the Columbia area.

National Stroke Congress

October 29-31, 1964

Chicago, Ill. — Palmer House

An intensive course to assist you in the Prevention, Management and Rehabilitation of a major medical problem—The Stroke Patient.

Program to include: The problem and prevention of strokes; The care of the early stroke patient; The convalescent and continuing care of the stroke patient; Community programs for stroke; Live TV demonstration of cerebral arteriography, ophthalmodynamometry, vascular surgery, management and rehabilitation of the stroke patient; One-act play on strokes; Exhibits and Films.

Sponsors: American Heart Association; American Medical Association; Heart Disease Control Program, U. S. Public Health Service; Vocational Rehabilitation Administration.

For Advance Registration Forms Write To: Ralph E. De Forest, M. D., Executive Secretary, National Stroke Congress, 535 North Dearborn Street, Chicago, Illinois 60610.

No Registration Fee.

U. S. Department Of Health, Education, and Welfare
Public Health Service

Assistance is asked in obtaining small serum samples from 1) patients with present evidence of anterior mediastinal tumors suggesting thymomas, *with or without* associated myasthenia gravis, aplastic anemia, etc., and (2) those with histories of resected thymomas.

A single 10 - 30 ml. bleeding from each patient is all that would be required. Containers and postage for the serum samples will be provided by the Institute on request. Serum samples, not clotted blood specimens should be sent to the National Institutes of Health. A report of findings will subsequently be sent to the physician.

Arthur J. L. Strauss, M. D.
Clinical Center, Room 12-N-258
National Institutes of Health
Bethesda, Maryland 20014

16th Annual Meeting, October 8-9, 1964
South Carolina Chapter, American Academy of General Practice

Clemson House, Clemson, S. C.

8:45 A. M., October 8

Speakers

John T. Cuttino, M. D.
Professor Pathology, Medical College of South Carolina

H. R. Pratt-Thomas, M. D.
President, Medical College of South Carolina

Robert B. Greenblatt, M. D.
Professor and Chairman Department Endocrinology, Medical College of Georgia

Perry S. MacNeal, M. D.
Internal Medicine, Pennsylvania Hospital

Hugh Mathews, M. D.
General Practice, Canton, North Carolina

Harry C. Shirkey, M. D.
Director and Associate Professor, Pediatrics
The Childrens Hospital, Birmingham, Ala.

Hervey M. Cleckley, M. D.
Clinical Professor of Psychiatry and Neurology, Medical College of Georgia

Edwin Boyle, M. D.
Assistant Professor of Research Medicine, Medical College of South Carolina

Julian R. Youmans, M. D.
Department of Neuro-Surgery, Medical College of South Carolina

UNC School Of Medicine Eighth Annual Symposium November 19-20, 1964, Chapel Hill

Postgraduate Course in Hematology With Emphasis on Clinical Aspects of Diagnosis and Treatment of Anemias, White Cell and Bleeding Disorders.

Staffed by the members of the Departments of Medicine, Pediatrics and Pathology at the University of North Carolina School of Medicine with Dr. Wallace N. Jensen, Professor of Medicine, University of Pittsburgh School of Medicine and Dr. Howard A. Pearson, Assistant Professor of Pediatrics, University of Florida, as guest participants.

A Syllabus of Cases to be Discussed will be Mailed to All Registrants in Advance.

A block of tickets to the Carolina-Duke game on November 21 has been reserved for those desiring them. *They should be ordered immediately.* Send checks ($4.50 plus 25¢ for mailing) to UNC Athletic Ticket Office, Box 930, Chapel Hill, mentioning the Symposium. Accommodations will be limited. The Carolina Inn and motels will give preference to those reserving rooms for both Friday and Saturday nights. Please make your reservations now.

Dr. Agardy Appointed

Dr. Z. L. Agardy has assumed the post of director of the Area Five Mental Health Center in Greenwood.

He is a native of Hungary and has been in this country since 1949. For the last eight years he has been on the staff of the State Hospital in Columbia, except for three years of educational leave when he did post-graduate study and work at the University of Arkansas Medical School and the Veterans Administration Regional Hospital in Little Rock.

A doctor of medicine, and a psychiatrist, Dr. Agardy has had his training in many countries and languages.

Dr. Mays Honored

Several hundred persons attended a surprise testimonial dinner at Fair Play School for Dr. William Clayton Mays, who celebrated his 78th birthday.

Other physicians, his pastor, fellow workers, relatives and plain folks who have known him for years spoke words of tribute and praise for the general practitioner who has delivered some 2,000 babies and administered to the ills of this rural farming section for half a century.

He completed his work at the Medical College of South Carolina in the Class of 1912.

Doctor For Hartsville

Dr. James O. Morphis has announced the opening of his medical practice in pediatrics at 800 Carolina Avenue.

Dr. Morphis, who has recently completed his special training as chief resident in pediatrics at the Duke University Medical Center, is a native of Greensboro, N. C., having received his B. S. degree from Guilford College in 1953 and his Master of Science degree from the University of North Carolina in 1954. He took his medical training at Duke University, graduating in 1958, his internship having been at Cone Hospital in Greensboro.

Dr. Morphis furthered his medical training in pediatrics as medical officer in charge at the U. S. Public Health Service Hospital in South Dakota. In addition to this training he received special training in infectious diseases of children at the Charity Hospital of Louisiana at New Orleans. He returned to Duke University Medical Center in 1963 and was then appointed chief resident in pediatrics during which time he taught developmental diagnosis at the Duke University Medical Center, and also completed intensive research in carbohydrate metabolism.

Dr. Morphis is a Board Certified Pediatrician and a Diplomat of the American Board of Pediatrics.

Dr. Bradham To Practice In Columbia

Dr. William S. Bradham, son of Dr. and Mrs. Allan C. Bradham, Anderson, opened an office for the practice of internal medicine in Columbia.

He enters medical practice after several years as a fellow teacher in medicine at the Medical College of South Carolina, during which time he did experimental and clinical research in diseases of the kidney. For the past year he has been a teaching fellow in cardiology at the same institution.

Dr. Bradham is a graduate of Boys High in Anderson, and University of the South at Sewanee, Tenn.

Following the completion of his undergraduate education he served four years as an officer in the United States Navy. He was graduated in 1959 from the Medical College of South Carolina where he was a member of Phi Rho Sigma medical fraternity.

He served his internship at the St. Louis City Hospital, St. Louis, Mo., and completed one year as assistant resident in medicine at the St. Louis City Hospital and one year at the Medical College Hospital in Charleston.

Dr. Carter Opens Office In Greenwood

Dr. Richard M. Carter has opened an office in Greenwood, specializing in ear, nose and throat. His office is at 614 Monument St.

Dr. Carter has just finished training at the Medical College of South Carolina. He also served an internship at the Medical College of Virginia at Richmond and had a year of training in general surgery at the Medical College of Georgia at Augusta.

He is a native of Langley in Aiken County.

Dr. J. F. Flowers

Dr. Joseph F. Flowers has begun the practice of general medicine in Walterboro.

Dr. Flowers will be associated with Dr. W. Marshall Bennett.

Dr. Flowers is a native of Colleton County and is a graduate of the Citadel and the Medical College

of South Carolina. Dr. Flowers did his internship at Spartanburg General Hospital.

He has just completed two years in the U. S. Medical Corps, at Fort Jackson.

Pacolet Gets New Doctor

Dr. Thomas F. Drake, Jr., formerly of Anderson, will practice medicine in the Pacolet area. His office will be located at 1 Montgomery Avenue.

Dr. Drake attended The Citadel in Charleston for two years and graduated from the University of Georgia with a degree in business administration. He then graduated from the Medical College of South Carolina and served his internship at the Baptist Hospital in Memphis.

Before coming to Pacolet, Dr. Drake practiced in Abbeville and Calhoun Falls.

Health Officer Completes 60 Years Public Service

Dr. William Kershaw Fishburne completed 60 years of medical service to the people of Berkeley county on April 10 and without a break in service, began his thirty-fourth year as a public health officer for Berkeley County.

Dr. Fishburne was born in Walterboro, April 10, 1880. He was graduated from Porter Military Academy in Charleston, after which he entered the Medical College of South Carolina.

Upon receiving his medical degree, the new doctor entered private practice in Pinopolis.

Through the years Dr. Fishburne has been the backer of civic improvements. He has helped to bring into being the Berkeley County Library, the Berkeley County Hospital, and the Berkeley County Health Department.

Hands Across The Line

Refreshing relief from the customary barrage of epithets across the Mason-Dixon Line comes to our attention in a book review published by the New England Journal of Medicine. The journal makes favorable comments about "A History of Medicine in South Carolina 1670-1825," by Dr. Joseph I. Waring of Charleston, and notes that it contains material of much interest outside the South.

The reviewer recalls that Dr. Waring, as librarian of the Medical Society of South Carolina, in 1957 supplied nine volumes of the New England Journal of Medicine and Surgery to fill in gaps in the files of an ancestor of the present New England Journal of Medicine.

"The recollection of the gift," the reviewer concludes, "makes all the more fascinating Dr. Waring's history as well as adding to the affectionate regard in which its author is held within this sanctum."

We welcome the friendly reception of an able account of South Carolina medical history accorded in another of the older centers of American culture.

—From the *News & Courier*, Aug. 2, 1964

Death

Dr. S. Darby Pendergrass

Dr. S. Darby Pendergrass, Jr. died July 23 in an airplane crash.

Dr. Pendergrass was born in Columbia. He was a graduate of the University of South Carolina and Medical College of South Carolina and took post-graduate training at the Department of Radiology at Bowman-Gray School of Medicine.

He practiced general medicine in Greenwood for six years prior to specializing. He was radiologist at Conway General Hospital before moving to Hartsville where he was radiologist at Byerly Hospital.

BOOK REVIEWS

NEW AND NONOFFICIAL DRUGS, published by the Council on Drugs of the American Medical Association. J. B. Lippincott Company, Philadelphia. 1964. Pp. 863. $4.75.

This annual publication of the Council on Drugs of the AMA is too well known to need much more comment than the statement that it is an extremely valuable tool for the practitioner, the researcher, and the editor. It describes drugs generally available but not included in the *Pharmacopoeia* or the *National Formulary*. The descriptions of the drugs are ample and authoritative.

This handbook can be recommended without reservation.

JIW

THE SPECIALTIES IN GENERAL PRACTICE. 3rd Edition. By R. L. Cecil and H. F. Conn. W. B. Saunders Company, Philadelphia and London. 1964. 676 pages. $17.50.

The avowed purpose of this text is to make readily available for the more isolated practitioner a source of reference for specialized types of problems that may arise. The subjects considered are perhaps helpful but are presented in either (1) too elementary a manner or (2) a hospital type of investigation when the necessary studies could be more effectively gleaned from another type of reference.

This cannot be recommended for the general practitioner or the student.

Charlton deSaussure, M. D.

PHYSICIAN–NURSE RELATIONSHIPS IN HEALTH CARE

J. Decherd Guess, M. D.
Greenville, S. C.

A recent news release from the American Medical Association told of a significant event in the continuing study of nurse-doctor relationships: At Williamsburg, Va., "Physicians and nurses sat down together at a national conference . . . to try to find out how members of the two professions can work together better in . . . providing . . . health care to patients."

Representatives of the American Nurses' Association and doctors, representing AMA, discussed together the changing patterns of practice in nursing and medicine, and some ethical problems and legal implications of these changes.

This conference was the first of its kind. No doubt it was a beginning of continuing efforts to bring about liaison between the two professions. It certainly did not decide any issues. It did bring into open view some of the conflicts in ideology of the two groups. It touched on nurse education only obliquely, if at all.

Participants agreed generally that spectacular advancements in the science of medicine demand significant changes in the art of medicine.

Dr. Cecil G. Sheps, professor of medicine and hospital administration at the University of Pittsburgh Graduate School of Public Health stated that the nurse is no longer a handmaiden of the physician with responsibility limited to the "Florence Nightingale" type.

Increasingly, he said, "procedures first developed by physicians may be performed quite effectively by adequately trained nurses." There can be no argument there. It is a delegation of duties generally authorized or requested by the physician and willingly and skillfully undertaken by the nurse. However, to so delegate these technical procedures, and to accept the tasks delegated, neither relinquishes the direction of treatment by the doctor nor makes of the nurse, who carries them out, a "practical doctor" as was alleged by Katherine R. Nelson.

Doctors are quite willing to give up the term handmaiden as referrable to nurses, since it has undergone a changed significance. It no longer appears to be a term of confidence, interested dependability, and appreciation, often to the degree of affection, to one indicative of a relationship of servant to master. Few doctors have ever looked upon the nurse who works with him as a menial. She has always been a most helpful co-worker. But times change and the significance of words change with them. Just as the term "pretty fool" and "wench," which in Shakespeare's time were expressions of affection, have come to be terms of derision, so, perhaps, has changed the term "handmaiden of medicine" when applied to professional nurses.

Miss Nelson, Ed. D., associate professor of nursing at Columbia University Teachers College, attempted to define an area of conflict between the professional nurse and the physician. (One wonders why there should be any conflict.)

She said that the physician sees himself as the leader of the health care team. That, he certainly is. It is he who is responsible for diagnosis and for determining the guide lines of therapy. He, so says Miss Nelson, sees the nurse as his helper. She resents the term helper and prefers the designation "associate." No kindly or understanding physician would object to that designation. However, he is not willing to concede that the nurse associate, however capable she may be, should make and apply judgments to the care of the patient independently. He cannot accept Miss Nelson's statement that it is the responsibility of the nurse to care for the ill "with or without a doctor," if, by care, she means to include diagnosis and the planning of needed treatment. She said, "Physicians are trying to turn the nurse into a 'practical doctor,' to use the nurses' services to administer intravenous injections or give transfusions, dress patients' wounds after surgery, and to solve the problems caused by lack of doctors, by getting the registered nurse to do their jobs."

One wonders if there is not a failure to communicate adequately when one speaks as did Miss Nelson. Her statement does not rightly describe either the effect or the significance of using nurses to do the several tasks she mentions. The nurse is frequently capable of performing those services. However, after all, the tasks are technical procedures and the doing of them does not make doctors of nurses in any sense of the word. The doctor determines the need and *requests* (the term doctor's orders has come into bad repute with many nurses) the nurse to perform the task as he outlines it to her.

If nurses are rejecting this division of responsibility and direction, as Miss Nelson states they are, if to be a professional nurse requires that she make her own "independent judgments" in this area of patient care, she is demanding responsibility beyond her training and competence, and is inviting not only continued conflict with doctors, but legal liabilities for which she will have little defense.

There is a wide "gray area" of technical procedures, both diagnostic and therapeutic, which can be performed equally as well by doctor and nurse. To delegate to the nurse the task of carrying them out, if within the range of her individual training and experience, neither makes of her a physician nor denies her competence as a careful, observant and communicative nurse.

Dr. Sheps, professor of medicine and hospital administration at the University of Pittsburgh Graduate School of Public Health, recognized and called attention to this gray area. He said: ". . . there is a growing body of tasks which can be performed by physicians, but which can also be performed by nurses," although some may require special training on the part of the nurse.

However, he went further than this. He predicted that "laboratory discoveries may very well be shared simultaneously and directly with nurses as well as physicians, thus emphasizing the responsibilities of nurses to share in decisions regarding the applicability of such developments to patient care." I quite agree that there well might be a sharing of determination of general principles of therapeutic action and the recognition of the danger signals of undesirable side reactions. There should be no sharing of applicability of these discoveries in any given case. Such sharing, if done, could be no more than a polite token gesture or an educational directive.

Mrs. Marion R. Flick suggested that the respective codes of ethics of the medical profession and the nursing profession might generate conflict between the two. She mentioned that the nurse by her code is obliged to determine what is good nursing practice. So long as the code limits "nursing practice" to the traditional concept of what constitutes nursing care, there can be no conflict with that demand.

However, in her remarks she continued: "The desire and need of nurses for self-direction may not be always understood. Nurses may, in asserting their comparatively recent professional independence, minimize the profound interdependence of our profession and clutch jealously at functions and responsibilities which must be shared with co-workers. Physicians may, in viewing developments in nursing, regard self-direction as rebellion against time-honored tradition. Is there a kind of competition for control, and does it reduce the effectiveness of our services?"

That there has developed a "jealous clutching" at functions and responsibilities by a highly vocal element of the nursing profession is clearly evidenced by an examination of more or less current literature, written or inspired, as much of it is, by these capable but highly individualistic women.

Mrs. Flick wisely said that "in order that skillful and safe care be assured every patient, there needs be a clear understanding among members of the health team as to which of the team can best perform necessary services." Jealousy as to one's prerogatives in performing such services does not provide a climate conducive to attainment of such an understanding.

Physicians freely acknowledge that the nurse should determine what is good nursing practice. However, they believe firmly that nurses must recognize that there is an interdependence of the two professions. They resent and believe it dangerous for nurses to demand professional independent direction of medical therapy.

Dr. Edmund D. Pellegrino, Chairman of Medicine of the University of Kentucky Medical Center quite correctly warned that "tasks must be delegated discriminately to those most capable of performing them [because] the physician can no longer provide for his patient all by himself. [The physician] must recognize his limitations, appreciate the skills of others, and be sensitive to his patient's need for services other than his own." He predicted that more "technical tasks" will be taken over from physicians by technicians and nurses in the future. However, I am sure that he did not mean to imply that these tasks should be taken over by technicians or even by professional nurses, without the direction and supervision of the physician.

Dr. Joseph F. Sadust, Jr., professor of preventive medicine and community health at George Washington University School of Medicine and Bernice E. Anderson, retired professor of nursing at Columbia University Teachers College, warned that as nurses accept greater professional responsibilities, they must be prepared to accept increasing legal obligations, since increased authority increases legal hazards. That fact, however, does not relieve the physician of his responsibility for the overall direction of the care of his patient.

Every kind of team, to be effective, must have and be responsive to a captain, or a leader. In the health team, the physician must be that leader. He is, and of necessity, must be, the ultimately responsible director.

However, it is equally true that there is a division of duties and responsibility among members of the team. The determination of the division may well be by consultation between all members of the team. Assignment of duties and responsibilities then can be made according to the capabilities of him who assumes those duties.

MINUTES
SOUTH CAROLINA MEDICAL ASSOCIATION*
116TH ANNUAL SESSION
HOUSE OF DELEGATES
OCEAN FOREST HOTEL MYRTLE BEACH, S. C.
MAY 5-6, 1964
ROBERT WILSON, M. D., Presiding

4:30 P. M., Tuesday, May 5, 1964 (Special Order) The Annual Meeting of the Corporation, The South Carolina Medical Care Plan.

The Chair: (Dr. Wilson) The House will reconvene at this time. I will turn the meeting over to the President of the South Carolina Medical Care Plan, Dr. John A. Siegling.

Dr. Siegling (Presiding): (Report of the President) Mr. President and Delegates, it is a great pleasure to be up here representing voluntary medicine, so ably extolled by Dr. Annis a short while ago. I am pleased to report to you that your Blue Shield Plan has passed the quarter million mark in membership. We now have 250,366 subscribers, representing a gain of 18.4% since my last report to you a year ago. Of a total income of $3,424,113.53, $2,808,217.04 or 82.1% has been paid to physicians in fees for their services.

Eighty-six per cent of the physicians of South Carolina participate by accepting service benefits, representing a broad base of enthusiastic acceptance of the plan. There have been very few complaints by physicians during the year, and the wholehearted acceptance and support of the Plan by the physicians of the state has encouraged the members of the Board greatly in the operation of the Plan.

During the year the manual was completely revised to reflect all improvements to date, and was printed and distributed to all South Carolina physicians.

A number of changes in the contracts and benefits have been made during the year. The non-surgical emergency care benefit, which was begun on a trial basis, last year, will be continued.

Skilled nursing facility care *benefits* are being added to all South Carolina basic *Blue Cross* contracts. There is *also* provision for fees by attending physicians *in* these facilities.

After much deliberation your Board has approved a $425.00 Surgical, Obstetrical and Anesthesia contract with service benefit income provisions of $5000.00 single and $7500.00 family. This amounts to allowances at $4.25 per unit, whereas the present highest contract is $3.75 per unit. Contract provisions are being developed to provide optional benefits as follows.

Medical benefits at $2.20 per unit under the Professional Services Index will bring allowances to:

In hospital, first day $16.50; second $11.00; succeeding days at $6.50.

Intensive (in lieu of regular), first day $33.00; second $22.00; third through fourteenth $11.00.

Consultation (1 consultant per admission) limited examinations $22.00; consultation complete with history, $38.00.

Effective February 1, 1964, all South Carolina Blue Shield contracts (not including the Federal Employees' policies) had their allowances rounded as follows:

1. Surgery and obstetrics round to nearest $5.00
2. Anesthesia round to nearest $1.00
3. Medical round to the nearest $0.25
4. Radiation therapy, diagnostic X-ray, pathology and laboratory, nearest $0.50

There has been a general trend nationally to relegate Blue Cross - Blue Shield patients in *wards* to the status of agency cases, for the purpose of residency training, and for the *fees* to be earmarked for residency educational funds. As a matter of fact, *seventeen* of the country's *seventy-one* plans knowingly pay for at least some services given by house officers. Your Board of Directors, at its meeting of March 8, 1964, reaffirmed its policy of not paying interns and residents for any of their services. It was generally felt that attending men and house staff should not be in competition for the health insurance dollar.

In the latter part of December 1963 the South Carolina Medical Association appointed a special study committee chaired by Dr. William T. Hendrix with the "intended purpose of acting as liaison between physicians and commercial insurance companies." This committee invited Blue Cross - Blue Shield to be a member, but it was felt that the Plans should not participate because they differ from the insurance industry almost diametrically, both in philosophy and practice. It is important to re-emphasize at this point that the Blue Shield Plan in South Carolina is an *actual part* of the state Medical Association. Members of its Board of Directors are elected by the state Association, and the House of Delegates constitutes the general corporate membership of the Plan. In addition to the president of the state Association, the chairman of council sits on the Board as ex-officio member, and the executive secretary of the Medical Association is an elected member.

For a number of years the medical men of the state have had the feeling that Blue Shield is a *surgical* plan for surgeons. It is worthwhile at this point, I believe, to point out that only 25% of South Carolinians with *commercial* coverage have in-hospital *medical* coverage, while 96% of South Carolina Blue Shield members have in-hospital *medical* coverage. It is quite apparent that the Plan has done much to include benefits for medical conditions. This is of considerable importance, considering the fact that a total 343,000 persons in South Carolina are covered by all *commercial* companies, and 250,000 by Blue Shield. Putting it another way—while Blue Shield covers 16% of those with *any* benefits for *any* type of physicians services, it provides 41% of the total of all in-hospital *medical* services and coverage.

Patients listen to what we say, and I believe that we have an unprecedented opportunity to advise our patients of the virtues of Blue Shield. Since it *is our* Plan, it is almost incumbent upon us to do so, and if

*This is an edited version of the minutes in which some of the routine parliamentary procedures and customary amenities have been omitted for lack of space. The verbatim copy of the proceedings is in the hands of the Secretary.

each of us in his daily contact with patients would extol the Plan, I believe that the task of our sales force would be much easier, and the Plan would undergo an adolescent growth spurt.

We should not forget that we have dedicated lay persons on our Board giving the benefit of their wisdom and experience to its deliberations. In each instance they have made personal sacrifice to attend the Sunday meetings of the Board during the year. The terms of several lay and professional members of the Board have expired, and I would like at this time to call upon the Chairman of Council, Dr. Burnside, for nominations for the Board.

Dr. A. F. Burnside, Chairman of Council: Mr. Chairman, Council nominates the following:

Dr. A. C. Bozard
Dr. Charles J. Lemmon, Jr.
Dr. Luther M. Mace
Mr. A. P. Nisbet, Mr. Thomas C. Vandiver
Mr. Raymond Pridgen.

The Chair: You have heard the nominations by Council for either re-election or election for membership of the Board of Blue Shield.

Dr. Wm. Weston: I second the nominations. (The vote was taken, by "aye" and "no" vote, and was unanimously carried.)

The Chair: It is so ordered.

At this time I wish to thank Mr. Sandow and his staff for their excellent work during the year. We should take great pride in having our Executive Director occupy the position of treasurer of the National Association of Blue Shield Plans, as well as chairman of the National Enrollment Committee.

One of the strengths of this Plan during the past few years has been the stability of its personnel. This year we have lost several key men, but the Plan has had capable persons already on the staff as replacements. The loss of John Alexander, former Director of Operations of our Plan, to the National Association of Blue Shield Plans as Assistant Director of the Statistical Research Division, gives some indication of the caliber of men we have. Mr. O. D. Masters, Jr., Manager of our own Claims Department, was available as a very capable replacement.

Our thanks go to Con Starin, assistant executive director; Hugh Fuller, enrollment manager; Gene English, public relations manager; William Marchant, controller; Leslie Patterson, claims manager; Bob Tomlin, professional relations manager; David Milling, professional relations representative; Charles Snipes, professional relations representative; and Eugene Porter, manager of tabulation systems.

I would like to inform you at this time that South Carolina Blue Shield has been invited by the National Association of Blue Shield Plans to participate in a survey to measure the effectiveness of fee schedules utilized by Blue Shield Plans across the country. You will be apprised of this individually by briefing letters in the near future. In two test areas physicians returned better than 90% of the forms. I urge you to participate in this survey and return completed forms so that the survey will be effective.

In conclusion, let me say that I have enjoyed the work of the Plan during the past year. It has been a privilege to serve. Please do not hesitate to let us know if you have any complaints or problems.

I mentioned earlier that nearly $3,000,000.00 of funds of the plan had been paid to physicians in fees during the year. And I want to emphasize here that this is an important economic factor in medicine in the state—but to those of us on the Plan I feel that we have a different philosophy. Those of us who work on the Plan believe that we are doing several things. We are carrying out the business of this Association, since we are elected to do so, and I think more than that we are serving the people of South Carolina in a way that they can't be served otherwise, and more than that we, on the plan, are dedicated to the philosophy that we are—in having this plan available in South Carolina—doing what we and representatives of medicine can do to include as many as possible of the people of South Carolina in a voluntary plan of insurance and as nearly as possible circumvent the federalization which is inevitable unless there are sufficient people covered under voluntary insurance. Is there any further business to come before the Plan? If not, I shall declare the meeting of the Corporation adjourned and turn the meeting over to Dr. Wilson.

The Chair: Thank you, Dr. Siegling.

(After recess and Special Order—Annual Meeting of the Corporation, The South Carolina Medical Care Plan.)

Dr. Robert Wilson, Presiding: We will refer to our previous order of business.

Dr. J. W. Wyman, Chairman, Medical Education Foundation: The following is a final report of the AMA-ERF committee for the fiscal year 1963-64:

Funds Contributed:	
Physicians	$16,029.50
Woman's Auxiliaries	1,068.76
Alumni Office	
Medical College of S. C.	2,500.00
Total:	$19,589.26

Respectfully submitted,
Joel W. Wyman, M. D., Chairman
Vince Moseley, M. D.
Benton M. Montgomery, M. D.

The Committee on Historical Medicine, Dr. J. I. Waring.

Dr. J. I. Waring, Chairman: I would like to read a supplementary report of the Historical Committee: After long delay the book by the chairman of this committee has finally appeared and has been distributed to the members who made request for it. Announcement was made several times in the *Journal*, once at least in the Newsletter, that the book would be sent only to those who asked for it. This was a matter of trying to control costs and waste and to conserve unwanted copies. Since the first distribution of 650 copies to members, the book has been put on sale and 160 copies have been sold up to the present. It was the thought of the chairman that any funds obtained from this sale could be applied toward the production of a second volume. As you may recall, the Association has appropriated funds over a number of years intended for the publication of the book. These funds, with a small amount from sales, have been adequate for the costs of publication.

It is not anticipated that there will be a large sale and therefore your chairman has already requested that the Association continue to appropriate an annual amount which may be accumulated for the publication of the second volume.

The book was printed in an edition of 1500 copies. Copies have been sent for review and the author has pre-empted the customary number. There are now 621 copies on hand. It is not likely that a larger number will be required and to print an extra 1,000 copies would involve a sum of about $3,000. No recommendation is made that we do this as in the event of any demand later, the book could probably be reproduced by offset process for a sum not appreciably greater.

The Committee on Coroners and Medical Examinations, Dr. E. A. Dreskin, Chairman.

Dr. Pope: Mr. President, in the absence of our Chairman, Dr. Dreskin, I would like to add to our written report. On May 1st the members of our com-

mittee met with members of the Bar Association committee that had been appointed by the South Carolina Bar Association. The Chairman of this committee is Mr. S. Augustus Black of Columbia, and other members are E. N. Zeigler, from Florence and Henry Smythe of Charleston. I would like to say that they received our information, both verbal and written reports, with enthusiasm, they were extremely kind and at the end of the committee meeting they stated that they were in sympathy with our efforts and would ask that their committee be made a permanent one. I think this is, the whole thing is quite a triumph when you get the bar and the doctors together and the meeting is amicable. The proposals that we had put to them were that we attempt to establish a pathological laboratory; with a state pathologist trained in forensic medicine; and third that we attempt to put through the legislature an adequate post-mortem examination bill. This is a most important bill for it will do many of the things that we would like to do to the function of the coroner's office, as the State of Georgia has done. We will have our bill put in by Senator Walter J. Bristow, Jr. of Richland County at the beginning of the next legislative session.

Again I was surprised when the Bar Association asked our counsel to get this bill passed—and when the Bar Association asks the Medical Association to help get a bill passed, I think it is worthy of comment. Thank you.

The Benevolence Fund, Dr. Thomas Goldsmith, Chairman.

Dr. T. G. Goldsmith: May I come up there doctor? Benevolence Fund Supplementary Report, May 1, 1964.

Dr. Wilson, Members of the House of Delegates, since my published report in the *Journal* I have the following additional report to make—the contributions which have come in since January 1 up to May 1, 1964.

Greenville County Medical Society	$100.00
Greenville County Medical Auxiliary	100.00
Lancaster County Auxiliary	10.00
Anderson County Auxiliary	50.00
Horry County Auxiliary	10.00
Sumter County Auxiliary	10.00
Newberry County Auxiliary	5.00
Charleston County Auxiliary	71.50
Total	$356.50

Then yesterday I received two checks that were made out around the middle of April so I added them to this present total:

Spartanburg Auxiliary	60.00
York County Auxiliary	25.00
Total	$441.50

Contributed by the Auxiliary with the exception of the $100.00 from the Greenville County Medical Society.

I wish to take this opportunity of thanking each donor for his support and interest in the Benevolence Fund. I also wish to extend my thanks and appreciation to the other members of the Committee for their continued interest and cooperation, that is Dr. Pettit and Dr. Lemmon.

Since my term expires with this meeting, I also wish to extend my appreciation to the previous committee members, Doctors W. Atmar Smith and O. B. Mayer who were members of the first committee.

The committee would like to make the following suggestions and recommendations:

1. That serious consideration be given by each medical society to contributing to the Fund.
2. That the Executive Secretary, Mr. M. L. Meadors, compile a suitable pamphlet giving the official constitutional set-up organizing the Committee and the rules and regulations that were drawn up and established by the first committee.
3. That such a pamphlet be distributed to each component society and the auxiliary societies.

Finally, I wish to thank the House of Delegates for the privilege of having served on this Committee since its inception.

Respectfully submitted,
Thos. G. Goldsmith, M. D., Chairman

(Dr. Goldsmith added in regards to #2, that the reason he is requesting this is that we have had inquiries from other states as to how our Benevolence Fund operates.)

The Chair: One further resolution of Council, Dr. Burnside asked me to present:

> Council recommends to House of Delegates that the present Committee on Nursing Education be continued under the present Chairmanship and report to Council at any time as it seems necessary.
>
> Signed: Alfred F. Burnside, Chairman of Council

The Chair: We will now have a report from the Chairman of State Board of Medical Examiners, Dr. George Wilkinson.

Dr. George Wilkinson: Mr. President, (Reading Board Report for 1963.)

The State Board of Medical Examiners met in 1963 on May 8th; June 17th, 18th, and 19th; November 11th, 12th, and 13th.

During the year the Board licensed 84 physicians by written examinations and 56 physicians by endorsement of credentials. Sixty-eight physicians were certified to other states. During the year 95 temporary certificates were issued. (Particularly to those who were in training in hospitals.)

In 1963 six disciplinary cases were heard by the Board, along with nine reports from previous hearings. One license was revoked.

The current terms of Dr. Harold E. Jervey, Jr. (at-large) and Dr. Harold S. Gilmore (6th District) expire this year.

Registration of physicians in South Carolina (passed by the General Assembly in 1963) has been very satisfactory; the Board appreciates the cooperation received from the physicians in the State.

A copy of the first complete directory was mailed to all registered physicians on November 1, 1963. On February 1, 1964 a supplement was mailed, bringing the directory up-to-date with additions, changes, deletions, and two corrections. Around August 1, 1964, a second, and last, supplement to the current directory will be prepared and mailed to all registered physicians in South Carolina.

It will be the policy of the Board, at intervals between the publication of the full bulletin, to publish any additional deaths, changes, or new people that move to the state. The Board would like very much to hear from any of you who find errors. In the first edition two errors were found, and these were corrected in the supplement. The supplements are printed in such a form that they can be pasted in the booklet without adding too much to its bulk.

During the year our Board has been represented by Dr. Harold E. Jervey, Jr., of Columbia, as a member at-large of the Board on the American Board of Medical Examiners. Here he has represented us quite well. He has been president, vice-president and now is secretary of the Board. It is a source of great pride to our Board that of the 50 Boards in America we should have an officer in the National group for these four years straight. Thank you.

The Chair: Do we have a report from the State Board of Nursing Examiners? Dr. L. V. Jowers.

Dr. L. V. Jowers: Dr. Wilson and Members of the House of Delegates. A year ago I was elected South Carolina Medical Association nominee for appointment to the State Board of Nursing Examiners and this appointment came through in November, 1963. Because of the importance of our nursing shortage and the lack of communication between the Medical Association and the Nurses' Association I bring you this report.

As background information there are several points that need to be publicized.

1. The total number of registered nurses in June '62 in South Carolina was 8,097 (this number includes nurses outside of the State.) In 1963 this number was 7,886, a drop of some 200 nurses. The ratio per 100,000 population in June '62 was 187 in South Carolina while the national ratio was 280. To maintain this present ratio, South Carolina will need 656 additional registered nurses by 1970. This is to maintain our present ratio. To match the national average, as now stands, we will need 3,193 more registered nurses by then.

2. To attain the ideal ratio of 350 nurses per 100,000 population in South Carolina we would need 5,103 additional nurses by 1970. As of July 1, 1963 there were 14 schools of nursing in South Carolina with a total enrollment, freshmen, juniors and seniors of 1060. These schools have a total capacity of 1346. This represents, roughly, a 79% utilization of facilities. In that same year, 1963, 310 graduates applied for and wrote the Professional Nurse Licensing Examination.

3. The State Board of Nursing Examiners is charged not only to examine nurses for registration but also to register, as accredited, schools of nursing in the survey for accreditation schools of nursing and to periodically re-survey all schools. The State Board of Nursing Examiners also has the same responsibility in reference to schools of practical nursing.

4. In 1961 only five diploma schools of nursing had 50% of their graduates to make a passing score on medical nursing. Only 3 had 50% of their graduates passing surgical nursing, and 4 had 50% of their graduates passing obstetrical nursing, and 2 had 50% or better passing ratio in pediatric nursing and 3 schools had 50% of their graduates passing psychiatric nursing.

In 1962 the problem had improved slightly. Six schools now had 50% or better of their graduates to pass medical nursing; while 4 had 50% of their graduates passing surgical nursing; four schools had 50% of their graduates passing obstetrical nursing and three had 50% or better of their graduates passing in pediatric nursing.

By 1963, improvement was much greater. Nine of the schools had 50% or more of their graduates passing medical nursing, and three of these schools had better than a 90% passing record. Eight had better than a 50% passing record in surgery and nine had better than 50% passing in obstetrics, and 9 in pediatric nursing.

This trend is further appreciated in summarizing that in 1963 the over-all percentage failure in the state was 18.7%, as compared roughly to 30% to 40% in 1961. This reduction in failures has been in large measure due to the intensive upgrading of nursing education during these years. The State Board for three years now has had a full time field representative who serves as a consultant for the schools of nursing and who spends much of her time in constructive criticism of the schools. This has made possible careful and complete evaluation of the schools curriculum, so that defects could be corrected.

It is to be expected that South Carolina will see a further reduction in its failures of applicant nurses for examination, an increase in the utilization of its total capacities for the production of registered nurses, and a marked increase in the production of licensed practical nurses. Thank you.

Meeting Adjourned
until
May 6, 1964, 9:30 A. M.

Wednesday, May 6, 1964, 9:30 A. M.

Call to order—

The Chair: As the first order of business this morning I will call on Dr. J. Chapman Milling, Chairman of the Memorial Committee for his report, Dr. Milling.

Dr. J. Chapman Milling: Memorial Address—1964.

Mr. President, Distinguished Guests, Ladies and Gentlemen, ten years ago I was asked by Dr. Richard Baker, then our president, to deliver the memorial address honoring the deceased members of this Association. There was little that I could then say, and there is little that I can say now, that could adequately express the exact mood and feeling that is appropriate to this subject.

Ten years ago I considered myself and my contemporaries as men, perhaps a little beyond midpassage, but still in the prime of life; as men and women who had attained sufficient experience to place them at the high tide of their usefulness. In the ten years that have gone by those of us who have survived have come now, perhaps suddenly, to realize that we are senior citizens. Whether we like to contemplate it or not, we belong to the age group that has become the province of the geriatrician. What is there to be learned from this sobering reflexion?

To the young interne, the resident and the younger men in practice, I should like to leave this thought. You have, according to the law of averages, some thirty-five or forty years in which to live and work. Take advantage of those years. In the beautiful and classical story of King Arthur, you no doubt recall the legend of the sword, Excalibur, given to him by a supernatural being who lived under the waters of the lake. A lovely woman's hand emerged from the water and offered the sword with the admonition that the young king was to use it valiantly on the side of right, that it would serve him well for a long lifetime but that one day he would have to return it to the source from whence it came. "However," she told him, "The time to cast away is yet far off."

I think that the sword, Excalibur, is symbolic of youth, for whom the time to cast away is yet far off. When youth is yours, you are to use it courageously and wisely, so that when the time comes to cast away you will have no regrets, no guilt for having misused your talents or for having shirked your responsibilities.

The same thought is admirably expressed in the closing lines of William Cullen Bryant's "Thanatopsis," a truly great poem written in the classic tradition of iambic pentameter and expressing a noble philosophy.

"So live that when thy summons comes to join
The innumerable caravan that setteth forth
To that mysterious realm where each shall take
His chamber in the silent halls of Death,
Thou go not, like the quarry slave at night,
Scourged to his dungeon, but sustained and soothed
By an unfaltering trust, approach thy grave
Like one who wraps the drapery of his couch
about him and lies down to pleasant dreams."

During the past year the following physicians of South Carolina have been called upon to render their account; have been notified that the "time to cast away" has arrived. As I read their names let us pause a moment in solemn tribute to their memory, looking tolerantly upon any faults they may have had, remembering with pride their virtues and their usefulness to the profession and to the public, their patients.

Deaths in 1963-64

Doctors—	
Bell, F. A.	Pearce J. C.
Boone, James E.	*Pettigrew, George
*Boykin, G. L.	*Pitts, B. G.
*Finklea, N. B.	Ross, Henry
*Highsmith, J. R.	*Smith, R. K.
Hill, R. D.	Symmes, J. M.
Hiott, J. T.	Tripp, C. M.
*Milford, J. C.	Whitaker, A. B.
Moore, A. T.	Woodruff, Frank
Assey, Philip	*Carter, Edward Peeples
Murdoch, J. W.	Frierson, B. D.
Parker, Wade	Brackett, N. C.

*Not members of the South Carolina Medical Association.

Mr. President, I move the adoption of this report and that we stand for a moment of silent respect to the memory of our deceased brothers. (Convention rises and remains silent.)

The Chair: Be seated. Thank you Dr. Milling.

Before we go into the reports of the reference committees, I would like to remind you of the dinner meeting tonight when Congressman Furlong from Florida will address the SCALPEL sponsored dinner. Whether he has the silver tongue and the golden voice to which we were privileged to hear and listen yesterday, we do not know, but I am sure that no one can be a congressman from Florida without being a very able speaker. I have never heard him, myself, but I hope as many of you as can will be there.

I received a telegram yesterday (Reading) "I am opposed to Medicare under Social Security. It is essentially an excuse to grab power by Washington. Bill Workman fought your fight in '62, we are doing it in '64, and ask your support in every way. No matter how conservative the democrat may be, when he gets to Washington he must go to bed with the liberals. Signed "Bob Doster, Republican Candidate for Congress, 5th District."

I suppose he means that figuratively and not literally—"going to bed." (Laughter)

Reference Committee Reports:

The Chair: We will now proceed with the committee reports and I will not call on them in the order in which they are listed in the program. For the first report I will call on Dr. Ralph Baker, Chairman of the Reference Committee on Insurance, Blue Cross and Blue Shield, Dr. Baker.

Dr. Baker: Mr. President, the report of the Reference Committee on Insurance, Blue Cross and Blue Shield.

The Committee met yesterday and considered the following reports:

1. Special Study Committee to communicate with the South Carolina Underwriters Association. This report was studied in detail and your committee recommends that it be adopted as presented. I so move, Mr. President.

(This was seconded, there was no discussion, the vote was taken, motion passed, and it was so ordered.)

2. Report of the Committee on Medical Hospital Contracts was received and considered in detail. The report was received, studied, and the Committee recommends that it be adopted as presented, and I so move.

(This motion was seconded, there was no discussion, the vote was taken, motion passed, and it was so ordered.)

The Committee received no report from the Committee on the Fee Schedule and therefore no action was taken.

(Motion was made that the entire report of Insurance etc. be adopted, this was seconded and motion carried.)

Respectfully submitted,

Ralph Baker, Chrm.	A. V. Williams
E. W. Taylor	R. V. Solomon
C. T. Weston	

The Chair: Thank you very much, Dr. Baker.

I will now ask Dr. Thomas Parker, Chairman of the Reference Committee on Legislation and Public Relations for his report, Dr. Parker.

Dr. Thomas Parker: Mr. President, and members of the House of Delegates, your committee met yesterday afternoon and took up the following resolutions:

1. The first one was a recommendation from Council that the Committee on Nursing Education be continued under its present chairmanship and with the duty to report to Council from time to time upon occasion.

The committee recommended the adoption of this recommendation. (This was seconded, there was no discussion, the vote was taken, motion passed and it was so ordered.)

2. The second report was from the committee on Nursing Education. We would like to commend this committee for the tremendous amount of work they have very obviously done. It has two specific proposals, or it has several, but there are two that I would like to clarify for you. The first one was that they recommend the creation of a new joint committee with the Nursing Association which would consist of 3 doctors and 3 people from the Nursing Association for purpose of liaison; and when that committee is set up—naturally, we can't appoint nurses or get their cooperation, but assuming that it is set up, then the present committee would probably fade out. But the first proposal is that we set up this liaison committee of 3 doctors and 3 nurses. In the meantime the recommendation, which you previously adopted—is to continue our Committee.

The second proposal is that we create a Board of Nursing Examiners, a Nurses Examiner Board, to consist of 4 doctors and 4 nurses with a nurse to always be the chairman. There was one thing that had become obsolete and that was that they recommended that we endeavor to get help from the state. This has been done, by the legislature.

Your Committee wishes to commend that committee for its work and to recommend approval of the report.

(This motion was seconded, there was no discussion, the vote was taken, motion passed and it was so ordered.)

3. The next and third report considered was that of the Committee on Legislation and Public Relations and again we think this committee has done a great deal of work. I would just cite these matters:

(1) Passage of the "Good Samaritan" bill which was referred to yesterday.

(2) Legislation to control the sale of non-magnetic BB Pellets, which cause eye injuries. Our committee found out that round pellets are all magnetic these days and it is recommended that this matter be held in abeyance and that we not press for this law at this meeting.



Dr. Roderick Macdonald

Now, as you all know air pistols have pellets that are not round, but at any rate it was the opinion of the committee, following consultation with the Ophthalmologists, that we let that matter ride for the time being.

(3) They wish support of a law for driver re-examination, the terms of which are not specified. The law would have to be drawn which might specify age and various physical conditions, but there should be a law to require re-examination of certain drivers under certain conditions.

(4) They wish a law to require safety belts in new cars.

(5) They wish a law to make reporting of physical abuse of children mandatory upon physicians.

(6) They wish a bill to provide for the sterilization of certain individuals. By and large we are talking about mentally retarded individuals. At the present time physicians who perform such operations may be in legal difficulty. So they wish to have a bill to provide that the Probate Judge or others can specify and authorize such operations and protect the physician who does the operation.

(7) Also they wish a bill to require prescriptions containing toxic drugs to be labeled with the generic name of the drug by the druggist.

Now, strangely enough there is no state which has such a law, there is no national law on the subject so that our executive secretary is studying this matter. The committee recommends support of all these things which I have mentioned to you.

This committee, also, would like to recommend the approval of the report of the Committee on Legislation and Public Relations.

(This motion was seconded, there was no discussion, the vote was taken, motion was passed and it was so ordered.)

4. The fourth Committee was that on Allied Professions, and this was a proposal that the State organization encourage friendly relations with the legal profession and the ministerial profession and possibly with others.

We received a communication from the Chairman that it was his opinion that this matter should not be entered into at this time, it was not to the advantage of the State Association to do so. It was the feeling of the Reference Committee that we did not have sufficient information upon which to base this judgment. Therefore, we recommend that the report be received as information and that the Committee be continued.

(This motion was seconded, there was no discussion, the vote was taken, motion passed and it was so ordered.)

5. The next Committee was the committee to study Health Organizations seeking endorsement of the South Carolina Medical Association.

Last year we did endorse Medic-Alert. We did not endorse The National Foundation but we did cooperate with them, giving them advice and consent. It was the opinion of this Committee that the South Carolina Medical Association would be unwise to endorse any organization over which the South Carolina Medical Association does not have control because we don't know what they are going to do—but that the South Carolina Medical Association should give advice and consent, when asked, and this was also the sense of the report of the committee.

We would like to recommend the adoption of this position.

(This was seconded many times from the floor.)

The Chair: Is there any discussion?

Dr. Frank Owens (Recognized): Mr. President, he said we should give "advice and consent when asked." Does he mean any organizations that ask us or would we be permitted at our discretion?

Dr. Parker: It would certainly be at our discretion as proposed—for our advice might be that you stop what you are doing, we don't approve of it—so certainly it did not imply that our consent and approval was automatic. It simply implies that we would not refuse to speak to somebody who wanted to speak to us and our answer then might be "no."

Dr. William H. Prioleau: Recognized)

It may be well to leave out the word "consent," leave it to advice or consideration, if that is all right?

Dr. Tom Parker (Chairman: I am sure the committee will accept that. We took the position that we did not think that we could be responsible for other organizations, so the position we are really taking is if they ask for our advice we will give it to them.

The Chair: Dr. Prioleau moves that the word "consent" be changed to "consideration," and Dr. Parker's committee accepts that change.

I will call for a vote on the proposed amendment to the wording, first—Dr. Prioleau's motion.

(This proposed amendment was voted on, passed and the ayes were unanimous.)

I will now ask for a vote on the original motion—is there any further discussion? (There was none.) That completes that part of your report, doesn't it, Dr. Parker?

Dr. Parker: Yes.

The Chair: All in favor say "Aye" (There was no opposing vote.) The ayes have it and it is so ordered.

(Continuation of Ref. Committee Report on Legislation & Public Relations—Dr. Parker, Chrm.)

6. The next committee report was that of the Mediation Committee, which had only two cases both of which involved misunderstanding between the doctor and the patient and were handled on that basis. We wish to commend the committee on their conciliatory ability and to recommend the adoption of their report.

(This motion was seconded, there was no discussion, the vote was taken, the motion passed and it was so ordered.)

7. The next report considered was that of the Accident Prevention Committee. This committee reported on 4 proposals. The first had to do with various suggestions for motor vehicle safety and to some extent overlapped the previous committee.

The second suggested labeling drugs containing toxic substances.

The third was a program on accidental poisoning on Educational TV which did take place.

The fourth one was a report on an educational program during National Poison Control Week, conducted in the schools.

We would like to move the adoption of this report.

(This motion was seconded, there was no discussion, the vote was taken, motion passed and it was so ordered.)

8. The next report considered was that of the Committee on Emergency Medical Care. This committee recommended that the South Carolina Medical Association should recommend to the Board of Health that a combined medical self-help, American Red Cross Basic First Aid Training Program be instituted in the public schools of South Carolina, on a continuing basis, starting at the 9th grade.

Now, the Committee stated that owing to the danger of atomic attack and other things that it was very likely that medical help might be hard to come by in the event of emergency, that this would involve training of the population to take care of what could be taken care of, alone, until they could get medical care, and the best way to do this would be through the schools, starting with the 9th grade.

Your committee would like to recommend adoption of this report.

(This motion was seconded, there was no discussion, the vote was taken, motion passed and it was so ordered.)

9. Next we considered the resolution from the Hampton County Medical Society that the South Carolina Medical Association study the possibility and advisability of suggesting to the State Legislature that its Kerr-Mills legislation be broadened and that the addition of a deductible clause be considered for higher income groups.

The Hampton County resolution proposed that our present legislation cares for the indigent but not for those who are just getting along but who would be overwhelmed by a catastrophe. So that they wished to provide for that and in this provision to possibly raise the income level—but if you took in the higher income level, knowing that they had a higher income, there should be a deductible provision so that they would pay the first certain amount, whatever that amount might be.

We think it is a good suggestion and recommend its adoption. (This motion was seconded.)

The Chair: This is an important matter, I think, and this is one of the situations in which I believe that we should speak as the State Board of Health, a constitutional advisor to the elected officers.

Is there a discussion of this portion of the report?

Dr. Parker: Mr. President, may I restate the proposition? The proposition was that we study the advisability and possibility of suggesting — so it would be a matter for study by one of our committees.

The Chair: Does your committee recommend which group should do the study, whether it should be Council or whether it should be a special ad hoc committee appointed by the president? Because you are in a position where you would have to suggest to the House exactly what the procedure should be.

Dr. Parker: This was not in the motion but I suppose an ad hoc committee would be what they were talking about, because this would not be, ultimately, a permanent matter.

The Chair: Dr. Parker suggests that the president appoint an ad hoc committee for the study of changes in the Kerr-Mills Act. That is the essential sense of your recommendation, I think, Dr. Parker?

Dr. Parker: Yes.

The Chair: A committee of five, I would suggest, about that.

Dr. R. Maxwell Anderson, Charleston (Recognized): While this is under discussion there are two points in connection with Kerr-Mills, since this is going to be brought for further consideration. In my experience, the two things that are lacking in a certain respect in connection with this law are 1) the general knowledge throughout the populace of South Carolina—in other words I think we should make plans to publicize this law more, as Dr. Annis suggested last night; 2) the fact that something is wrong with the State Board of Health requirements in connection with this law. It takes thirty days to get people approved, except on emergency basis and an emergency basis is always difficult to handle. I know this varies somewhat in different counties, I believe, but I think this other point should be considered. The two points are 1) further publicity; and 2) somehow facilitating the red tape of handling this application.

Dr. Frank Owens (Recognized): I believe Dr. Anderson meant to say the "Public Welfare" and not the "State Board of Health" for the Board of Health does not pass on these things. It is handled by the Public Welfare in the State.

The Chair: Is there any further discussion?

Dr. J. I. Waring: (Recognized) May I call the attention of the House to the fact that the Public Relations Committee, the Hospital Association and Blue Cross - Blue Shield distributed 100,000 pamphlets outlining the Kerr-Mills provisions—we sent them out requesting the doctors to distribute them—how far they have gone I don't know.

Dr. Donald G. Kilgore, Greenville (Recognized): I would like to bring up one point for consideration by this committee when it is formed, in many states the money available under Kerr-Mills is utilized by insurance policies for these individuals, either Blue Cross - Blue Shield or some form of commercial insurance. I believe this is done at the present time in six states and had been reported highly successful. I would bring this up for consideration by the committee. It might not work in South Carolina, but on the other hand it might work quite well. Thank you.

The Chair: Is there any further discussion? The motion is that an ad hoc committee be appointed to study possible changes in the Kerr-Mills legislation and I suppose recommend those changes back to the House for approval and, if approved, then to the proper legislative authorities. (There was no further discussion.)

(The vote was taken on the motion, the motion passed and it was so ordered.)

This is an action by the House and I think probably the House of Delegates is the one, but certainly it might well be referred back to Council.

(From the Floor) It is a year until we meet again. I think Dr. Parker has a good point that it probably should be referred to Council and have an opportunity to act on it, maybe implement it.

The Chair: Council will meet in the fall, I will suggest that Dr. Owens, when he appoints the committee, that he will ask for a report at the fall meeting of Council.

Dr. Parker: (Continuing report of Reference Committee on Legislation and Public Relations.)

10. The next report was that of the AMA-ERF Committee, for the fiscal year 1963-1964. The brief report was that total contributions of $19,598.26 had been received. The committee recommends the receipt of this as information, with thanks.

(This was seconded, there was no discussion, the vote was taken, motion passed and it was so ordered.)

11. The next report considered was that of the Special Liaison Committee with the South Carolina Medical Association and the Department of Public Welfare. Now, this report consists of the minutes of the meeting which was held March 18, 1964. It is recommended that this be accepted as information.

(This motion was seconded, there was no discussion, the vote was taken, the motion passed and it was so ordered.)

That concludes the report of our Reference Committee on Legislation and Public Relations, Mr. President, and I move the adoption of our report as a whole.

The Chair: Dr. Parker's report as a whole is approved. Thank you, Tom. Next, I will ask for the report of the Reference Committee on Amendments to the Constitution and By-Laws, Dr. Rudolph Farmer, Chairman.

Dr. Rudolph Farmer, Chairman: (Recognized)

This report has to do with a proposed change in the by-laws, specifically with Chapter V—Section II which governs the present regulations covering the election of councilors. It is a report of a Study Committee which met in October of 1963 and formally drafted and recommended these changes.

The reference Committee considered this yesterday and I think the meat of the matter is this "The Councilor for each District shall be elected by the County Societies comprising such District, in meeting assembled, at least two months prior to the Annual Meeting of the South Carolina Medical Association at which the term of office of the incumbent Councilor expired. Each County Society in such election shall have one vote for each member of the House of Delegates to which it is entitled."

After considerable discussion and study the Reference Committee recommends that this be accepted, and I so move its adoption, Mr. Chairman. (This motion was seconded.)

Dr. Norman O. Eaddy (Recognized): I would like to ask a question. Is this recommendation of those districts binding on the House of Delegates, is that the proposal?

Dr. Farmer: Yes, I think that it would be. We discussed the advisability, frankly, of having the action of the District delegates in the election of councilor, approved by the House of Delegates, generally—but that was not included in the recommendation.

Dr. Eaddy: I ask that because one or two of the districts did not meet; they might not meet at all.

The Chair: If they don't meet they will not have a nomination. My understanding would be the District would make a nomination but that election to the Council would have to be carried out by a vote of the House of Delegates. I would also interpret it to mean (it won't come up this year) that probably another nomination could be made from the floor. This proposal, I believe, was made last year and it has been circularized among the membership and it does mean an amendment to the Constitution which will require a two-thirds vote.

Dr. Stone: The intent of the Committee was this was not to be voted on, actually, by the House of Delegates but that each District would nominate and actually elect a member of council and so inform the House of Delegates that he is elected. This would be withdrawn, change Section II of Chapter V whereby the nomination for council would not be made on the floor of the House of Delegates but be elected by the Districts and the membership so informed.

The Chair: I do not know what future presiding officers would rule but it probably would be that the councilor is an officer of the Association and that no part or group of the association could possibly be privileged to have the complete control of the election but the election would have to be carried out by the House. What would be your interpretation of that, Mr. Meadors?

Mr. M. L. Meadors, Executive Secretary: I think in the manner in which the Constitution stands at the present time that would be correct, Dr. Wilson.

(From the Floor) This is a proposed amendment to the Constitution?

The Chair: Yes, it was proposed last year, it was studied by a special group, it was circularized to the membership and it is now for approval or disapproval at this time as an amendment to the Constitution.

Mr. Meadors: If you are sure that it was proposed as an amendment to the Constitution last year, it is all right. That was not my recollection.

The Chair: The secretary is not here to consult the minutes.

Mr. Meadors: If I recall correctly the suggestion was made that this change be entered into; a special committee was appointed to study it, Dr. Stone was the Chairman of the Committee, but I do not recall it was proposed as an amendment to the Constitution.

Dr. Stone: That was brought in as a resolution last year as a proposed change to the Constitution and By-Laws. Our committee was appointed to study it and we brought this report in recommending the change in the By-Laws.

The Chair: This, then, is the first proposal for the change?

Dr. Farmer: This is actually the report of Dr. Stone's Committee.

The Chair: In that case, the Chair will rule that this cannot be put into effect at this time, as an amendment to the By-Laws, but this is a proposal and your committee recommends this change?

Dr. Stone: Yes, sir.

(*From the Floor*): What is the purpose of this change?

Dr. Stone: This is the second time, Dr. Wilson, it was proposed last year, it was reported out favorably from the Reference Committee, which in turn appointed our Committee to study it in detail and we brought the report back and circularized it two months prior to this meeting and this is actually the second time it has been brought up.

The Chair: (To Dr. Farmer) Can you answer the question?

Dr. Farmer: I don't know that I can. I do think this, that we were of the opinion that because of the fact that this Committee had continued this study from last year, and treated this report in October, and it was circularized in the *Journal*, that we could present it for acceptance.

The Chair: I mean the question that was asked "What was the purpose behind this proposed change?"

Dr. Farmer: I think maybe Dr. Stone's Committee went more into detail with that. I think the reason for this thing coming up has been the control of the election of the councilor from certain districts by one county whose delegates' vote was preponderant. Am I correct in that, Dr. Stone, wasn't that the chief reason for this amendment?

Dr. Stone: Yes.

Dr. Pope: Dr. Wilson, I served on the Reference Committee and I would like to plead in behalf of Dr. Stone's Committee and their proposal. Specifically, this was brought forward because the control of the councilor in a district does not lie within that district's vote. Dr. Stone is too polite to say that several years ago four counties in their district endorsed a certain individual and yet by the state-wide voting, a man from the fifth county was elected. I feel and his committee feels, and I so spoke to this Reference Committee yesterday, that the control of the election of a councilor should be within the rights of the men who are elected delegates in that respective district. I think very few men from Charleston, Orangeburg or Greenwood would expect to go to Chester to vote for the successor at the Congressional District. This is the same thing, it is a representative of a certain segment, why shouldn't they control the election of their own councilor. I think if you bring this back and answer specifically "why the change," if you bring it back and have the House of Delegates pass on it and have nominations from the floor you are taking away the control of the election of the councilor from the respective district. And that is specifically why they should not be brought back to the floor. The election takes place two months prior to the next meeting, to fill a vacancy, and it should be binding on the House of Delegates.

Dr. Norman O. Eaddy: I am all for this motion. I have been for several years. I think if put to a vote, the majority will be. An amendment of the By-Laws can be made at any time. The only point I had in mind was—I would hate for council to lose the services of some person because some district happened not to meet or happened not to meet two months before the state meeting of the House of Delegates. And I would make this suggestion—in case a nominee is not elected by the district and that vacancy arises here on the House of Delegates and no nominee is forthcoming, then the House of Delegates might elect.

Dr. Halsted Stone (Recognized by The Chair): In the Constitution and By-Laws, under Chapter VII, Section 4 or 5, it says "under Duties of Members of Council" that they should meet annually with each Chapter within their district and goes on and says they are organized—therefore the constitution ought to give the president and the council the authority and power to call that meeting and if he doesn't call that meeting, why he is negligent in his duty.

The Chair: Our counsel says that this cannot be voted on, finally, in its present terms this year, as an amendment to the constitution. I have asked his advice on this matter.

Dr. Weston: I would like to state in favor of the motion that I think it is giving the individual delegate to the South Carolina Medical Association more control over the affairs of the Association. I think at the present time that groups and cliques can select the officers and councilmen without the individual delegate having the individual control over his regimentation. And we are speaking in the same terms as the congressmen are elected; you are giving that congressional district its opportunity for the election of its congressmen and its councilor. I think we should pass the amendment.

Dr. O. B. Mayer (Recognized by The Chair): Mr. President, I am speaking against it. I feel that there would be circumstances that would come up where it would not be wise for the state as a whole. The Councilman serves on a state-wide basis. I think that the individual districts have the right and privilege and they should suggest or nominate, if you wish, but I think the final decisions should be up to the House of Delegates. Thank you.

The Chair: Is there any further discussion?

Dr. Thomas R. Gaines (Recognized by The Chair): I wonder about the possibility of adding an amendment "that in case the district does not present a nominee, that the House of Delegates shall elect the councilor from that district?

The Chair: You propose that?

Dr. Gaines: I would like to have some discussion on it to see what others think about it, if they approve it.

The Chair: Dr. Gaines' proposal is made that the wording be changed so that if the district does not nominate its own councilor the House of Delegates, of course, is free to elect.

Dr. Farmer (Chairman of Reference Committee): It would seem to me, Mr. Chairman, that since there are differences of opinion, and certainly since the legal opinion at this time is that we cannot vote on this proposal, that the Special Study Committee be continued and given time to smooth out the differences that have been expressed here today. I would suggest that we do that.

The Chair: Now, what exactly is your recommendation? That the present proposal be referred back to the Study Committee for change?

Dr. Farmer: That is right.

The Chair: I would interpret this to mean that this is proposed at this meeting as an amendment to the Constitution which will be finally acted upon next year, but further study with the discussion of the various points raised, in mind, that it be referred back to this committee for report next year, again.

Dr. Farmer, Chairman: Yes, based on the legal opinion of Mr. Meadors that it cannot be voted on at this time.

The Chair: Is there further discussion?

Dr. Frank Owens: Mr. President, this is proposed today, what would be the effective date? I assume it would be the year following the adoption, if it were adopted.

The Chair: If it were adopted today, it couldn't effect the election of councilors at today's meeting. If adopted next year, likewise, it would have to hold over to the following year for the election of councilors at that time.

Is there further debate?

(*From the Floor*): Would that so be included in the motion? The effective date, would it be included in the motion?

The Chair: The study committee will certainly take that into consideration, but if the wording is, as suggested, that the nomination for council must be made two months ahead of time it couldn't possibly be effective until the following meeting after its adoption.

(*Question from the Floor*): Wasn't Dr. Gaines suggestion in the form of a motion?

The Chair: He did not move that, but I am sure his discussion is pertinent and will be considered by the committee.

Delegate from the Floor: Since this proposal can be voted on next time, I would like to amend the recommendation that the effective date be the following year.

The Chair: That is the year following any adoption, if it is adopted. Is there any further discussion? If not, are you ready for the question? All in favor of the adoption of this motion to refer this back to the committee for further study and to report at the House of Delegates at the meeting next year—say "aye". (There were many ayes, and a few "noes".) The ayes have it and it is so ordered. (Upon sug-

gestion from the floor the Chair stated that it should be recorded as a proposed amendment to the Constitution, and it can be acted on by the House next year.)

(Following is a copy of the amendment as recommended by the Special Study Committee, concerning election of council.)

"The Special Study Committee of Election of Council met at the Columbia Hotel, October 10th, and recommended the following changes in the By-Laws:

Amend Chapter V—Section II of the By-Laws, by striking out the words "that for the office of" on lines one and two of said Section, and inserting in their place, the words "those for the offices of Council and," so that said sentence when amended shall read as follows:

"Section II. Nominations for office except those for the offices of Councilor and Treasurer shall be made from the floor."

Amend said Chapter further by adding a new Section immediately after Section II to be number Section III and by renumbering the following Sections of said Chapter to conform, the new Section III to read as follows:

"The Councilor for each District shall be elected by the County Societies comprising such District, in meeting assembled, at least two months prior to the Annual Meeting of the South Carolina Medical Association at which the term of office of the incumbent Councilor expired. Each County Society in such election shall have one vote for each member of the House of Delegates to which it is entitled."

Respectfully submitted,
Halsted M. Stone, M. D., Chrm.
Hugh H. DuBose, M. D.
Joseph H. Cutchin, M. D.
V. Wells Brabham, Jr., M. D.
Sol Neidich, M. D.

Dr. Farmer: That concludes the report of our Reference Committee, which consisted of myself, as Chairman, W. W. King, J. A. Siegling, C. R. May and D. S. Pope.

The Chair: The next Reference Committee Report will be on Public and Industrial Health, Dr. Swift Black, Chairman.

Dr. Swift Black, Chairman: Mr. President, members of the House of Delegates, our committee considered the following resolutions and reports:

1. A resolution opposing area-wide planning for hospitals, presented by the Greenville County Medical Society.

The Committee agrees in principle that Federal control should be avoided at all costs. We recommend that the resolution in its present form be not adopted. We do recognize, however, that the problem exists and suggest that this resolution be referred to Council with the idea of an ad hoc committee being established to study it further, and we so move.

(This was seconded by Dr. Gaines, and others, the vote taken and it was so ordered.)

Dr. Parker: Will there be any discussion in this matter?

The Chair: (Laughing) Yes, sir, I failed to ask for discussion.

Dr. Parker: Mr. President and Members of the House, the reason that this resolution was brought up possibly in the rapid form is because the matter is urgent. Now, this matter has been cooking in the mill for several years and it has been available in writing, in governmental publications, and other publications for several years, but all of us are busy practicing medicine and we just don't see it. But actually, as of the present time the federal government is implementing the study—not the closing of the hospitals, which I will mention, but is implementing the study in several states right now. It is being actively pushed for congressional adoption, right now. A bill to do so has already passed the Senate, with debate. I take it that those who might have been opposed to it voted without even knowing. At any rate Senator Humphrey did present a Bill and it was passed without debate and it was sent to the House. The forces that are pushing for its adoption are powerful and they consist, of course, of the federal government through the Department of Health, Education and Welfare; Labor through CIO, the American Hospital Association, and Blue Cross. Now these proposals are drastic and very briefly they are: that committees are to be set up in each area. Now, by definition, an area contains about 30,000 people, it doesn't contain a definite number of square miles. It can be a county or it can be something else. But these committees are to be set up and they are to be set up voluntarily, if possible, and they wish to get the prominent citizens—who know their own business but know nothing about hospital administration or medicine to lend an aura of respectability. If citizens will not voluntarily form such a committee, then they are to be set up by state law. Efforts are being made to push this through the different legislatures—I am not aware of our legislature but it is being pushed in state legislatures, right now. The committees to be set up will have ironclad control, as follows: They will control the construction of all new hospital beds; they will control the maintenance of existing beds; they will control the utilization of these beds—in order that all these plans can work nicely and nationally, right on up, and there will be no conflict with here and there. It is being pushed by the American Hospital Association, in spite of the fact that the proposal, if adopted, would mean the closing of all 50-bed hospitals, essentially, as soon as the matter is adopted, and all 75-bed hopsitals as soon as possible, thereafter, on the grounds that these are inefficient, and you can't practice good medicine in a little place like that. Moreover, it contains the interesting provision that this committee shall discourage the provision of any other beds by anybody else. In other words, it will discourage private hospitals, it will discourage—the word as used by them means "prevent"—that is what we are talking about. If any of us were foolish enough to build a hospital we couldn't do it, they would not allow it. There has been a case out in Michigan, where a hospital did enlarge itself, without consent of the area-board that they have there, and it submitted Blue Cross bills and Blue Cross endeavored not to pay them, specifically on the grounds that the hospital authorities had not consulted them, and further that they had no right to build these beds and that it would jeopardize the whole thing.

It is perfectly obvious that if they set up a committee, a committee which controls the beds as tightly as that, they are going to control who uses those beds and this includes doctors and patients. The concept is, except in rare instances in small towns and such, they will close the hospitals and they will have ambulances and they will just take the patients somewhere where the people can treat them right. The matter is very serious. This is essentially identical. It may not be identical but it is very close to identical to a resolution which has been passed by the Texas State Medical Association, and it is being considered in various other state associations with the hope that we can get AMA to take the matter up in June in San Francisco. I have no objection to an ad hoc

committee—but what we are trying to get is official nation-wide action on our part to protect all of us, and also to protect our hospitals. So that I would urge upon you that the motion, which is presented, is that we ask our delegates to San Francisco to bring the motion up for discussion, at least, and action out there, if possible, which perfectly obviously if brought up out there may not pass in this form—so that I would submit, if we are in favor of the proposition, in principle, then we ought to adopt the motion. Thank you.

Dr. Kilgore (Recognized by The Chair): One point Dr. Parker did not mention is this bill not only covers Hospital Planning facilities but it also has broad and wide-spread powers effecting water and sewerage facilities, use of land, and also *future* use of land. In other words if you have planning and zoning commissions in your individual counties or in your individual area, this "Area" Committee will supercede the authority of the local committee which you have. This is a tremendous power grab and the verbiage of the bill is very loosely written. I have consulted two lawyers and they tell me the president or his directed authority can do just about what it pleases with the bill as loosely worded as the Civil Rights Bill is and all of you know how many constitutional amendments and provisions of the Constitution that Bill violates. This Bill is just about as vicious in its broad-sweeping powers that it grants to the President or his designated authority, it may be some bureaucrat up there in Washington which you have no control over, and may not even know, but he will indirectly control your life by this Bill. It also includes airport facilities, practically anything you can mention.

I urge with Dr. Parker that you reconsider your opinion on this bill.

The Chair: Is there any other discussion?

Dr. Swift Black: Is Mr. Sandow in the House? I would like to have permission for him to speak to the House, if possible. He appeared before this committee last night and gave some other views and also Dr. George Dean Johnson, if he is here?

The Chair: Is Mr. Sandow in the house?

Mr. Connor Starin: I am Bill Sandow's assistant. I am sorry he is not here. I think, if I may discuss this position, completely without portfolio.

The Chair: Mr. Starin, would you come to this microphone, please.

Mr. Starin: Obviously we don't feel as the people do who presented this resolution and I don't like to be in the position of arguing a point, but I think that the evidence that exists with respect to planning councils, wherever they exist, so far, in this country is that these are voluntary community civic groups who have accepted the responsibility for at least a portion of the economics of the health care in their community. The evidence is that these groups, by whatever name they are called, are only advisory. They have no power, they have no legal status whatever in their community, but they work to help administer the provision of Hill-Burton Funds and the matching funds that have to come from their own community in a fashion that will be as effective and efficient as possible. This is a matter of record. I can't argue the point of what somebody feels or what somebody thinks is going to happen, or what somebody says somebody else is going to do, I only know about the record, insofar as these councils actually exist in this country.

Dr. Black: Thank you, sir.

Dr. George Dean Johnson (Recognized): Mr. President, Members of the House of Delegates, I did appear before this Committee, yesterday, to express the feeling of Blue Cross on County or Area-Wide study of hospital facilities. Blue Cross does not favor compulsory studies. Blue Cross favors voluntary area or county studies and the reason is that in some places, notably Cleveland, hospitals are built—you and I can't imagine this—hospitals are built with no regard for demand for beds. As a result the lower the utilization, the higher the cost. As you know, any time you add a hospital bed in your community the total cost per day of hospitalization goes up. This is so well known that the Blue Cross has gone on record as favoring county, or an area, or a city-wide study of hospital facilities before a new hospital is built or before beds are added to a hospital. Now, I certainly agree with Tom Parker, I don't think this thing should be compulsory. I don't think people from Washington should come to Spartanburg, or Greenville or Columbia, or Charleston or Florence or anywhere else and say "Well, you need some beds, or you need no beds, or we are going to close this bed." We are certainly against that, but I hope that you don't take the attitude that you are against county-wide study of hospital facilities, because Blue Cross is only interested in keeping hospitalization as low as possible. Everytime hospitalization goes up, Blue Cross gets the blame and you and I know that they are there only to collect for the hospitals and to send it back to the hospitals. So, whatever is done—please don't get the idea that a study of hospital facilities is not necessary and is not good, because it is. We are all against compulsory and certainly a centralized study and dictation from Washington.

Dr. George Durst (Recognized): I am sure that our delegates to AMA enjoy the full confidence of this House of Delegates. I move a substitute motion that they be sent uninstructed on this matter and authorized to act as they see fit as it comes before the AMA meeting next month.

(This motion was seconded.)

Dr. Kilgore (Recognized): Mr. President, I agree completely with Dr. Johnson. I think voluntary planning committees are an excellent thing and certainly I didn't mean to imply that I opposed this. All that I am interested in opposing, and I think you all are too, is compulsion from Washington. But unfortunately this Bill S-855 gives extreme authority to the President or his designated authority. I believe we should have area-wide planning and I believe it should be done on a voluntary basis, and I am completely in agreement with you on that score, but the only thing I plead for is that we oppose S-855, which I think is a rather vicious grab for power.

Question From the Floor: Mr. President, why is it necessary to pass legislation in order to give people voluntary control of their area? This is the point of the whole thing.

Dr. Parker: Going along with what Dr. Kilgore said, we all approve of planning, of course, we are talking about compulsory planning. I might mention as regards utilization and hospital costs, the plan is that our hospitals will be of such size that they will be 85% to 90% full, all the time. I don't know how it is with your hospitals but the Greenville Hospital comes pretty close to being 102% full, all the time. But the plan is that they won't be over 90% full, barring an emergency.

As regards compulsion, let me get this S-855 Bill, you have it, Dr. Black, (Getting the bill). This isn't a long bill. I am not going to read you very much of it, but I would like to read you one little thing here:

"Compulsory planning" includes the following, . . . (1) preparation, as a guide for long-range development, of general physical plans with respect to the

pattern and intensity of land use and the provision of public facilities, including transportation (including everything, everything comes under that). (2) Programing of capital improvements . . . . (3) coordination of all related plans of the departments or subdivisions of the government concerned; . . . . (5) preparation of regulatory and administrative measures . . .;" and it goes on to say, (Reading Page 2, Sec. 2. (a) Except as provided in subsection (b) of this section, "each application for a loan or grant of the type described (and that is Hill-Burton, among other things) *shall* be accompanied (i) by the comments and recommendations with respect to the project involved by a planning agency designated to perform metropolitan or regional planning . . . and (ii) by a statement by the applicant that such comments and recommendations have been considered prior to formal submission of the application." And the exception is that if they have already considered it or if the board has had it for a period of 60 days and hasn't done anything, then they can do without it.

But you can talk about "voluntary"—if you have got to have the approval of the planning board, it is not voluntary.

We are in favor of planning, of course. You have got to plan. But we are opposed to compulsion, and this is compulsion. And, certainly, I have great confidence in our delegates—I voted for both of them, I see them at meetings, but again, what we are asking is that this matter be brought up, and it should be brought up.

Dr. L. Charles Bailes, of Anderson (Recognized): I agree with Dr. Parker, entirely, on the fact it should not be compulsory. We have just had a discussion about whether or not districts should be represented by their own councilors, and I am opposed to any minority faction. I think at this point, so far as I am personally concerned, I don't understand this Bill well enough to decide either way. I think it would not behoove us to take the responsibility in the hands of a few individuals at this time to make a plan, what would be obviously the proposal of all the doctors of the State of South Carolina, without first each doctor, every doctor in the state having an opportunity to formulate his own opinion. It may be that we will all formulate the opinion that Dr. Parker proposes, however, I don't think enough of us have had opportunity to understand this and act on it as individual citizens in our own territory and understand the Bill. I think before we take any attitude, that we ought to recognize that this is a democracy and each one of the doctors in the state should have the right to make his own decision and these things should be carried back to our county before making any representative from this group speak for the counties without their voice.

Dr. Colvin, of Spartanburg (Recognized): Less than three weeks ago I was on a reference committee of our national cancer meeting in Atlantic City, and frankly when one American Hospital Association man, who attended the meeting came down he said this Bill has a lot of ramifications—so I would plead with this House of Delegates not to rush into anything. I, too, have all the confidence in the world in our two delegates, but I also have a jaundiced eye when the Department of Health, Education and Welfare starts pushing something because they not only use the front door, the side door and the back door but the trap door.

Dr. Timmons: (Recognized): I want to second what Dr. Bailes said. I think Dr. Parker has given some alarmist talk. 50-bed hospitals and 75-bed hospitals being closed and transporting patients to hospitals—he has read things into this bill that are not there. I think we ought to defer action and leave it to the good judgment of our Council.

The Chair: Any other discussion. (The question was called for.) On the amendment of Dr. Durst, it was seconded, all in favor of his amendment make it known.

Dr. Thomas R. Gaines (Interrupting): Mr. President, may I ask that the original be read and then the amendment?

The Chair: I failed to call for discussion. We almost made it.

Dr. Swift Black: (Reading) Your reference committee, realizing that great debate was on the horizon took the attitude and I quote "We recommend the resolution in its present form be not adopted. We do recognize, however, that the problem exists and that this resolution be referred to Council with the idea of an ad hoc committee being established to study it further, and we so move." (This was seconded.)

The Chair: Now, we will vote on the amendment.

Dr. Durst: I made a substitute motion, but it doesn't matter because it is undoubtedly going to come up at the AMA meeting next month, and we should not tie the hands of our delegates but leave them uninstructed and trust to their good judgment having received the benefit of this discussion of the House of Delegates here at this time, I move the substitute motion that they be instructed to act on their judgment in the matter.

Dr. William Weston: I would like to add an amendment to that, the sense of this delegation is they are against federal control.

Dr. A. C. Bozard (Presiding)—

All in favor of Dr. Durst's substitute motion that the delegates be sent to AMA with their hands not tied to act on this question—please vote by standing. (Almost all the delegates stood.) I think that is a majority.

Now, the original motion or resolution of Dr. Black has been seconded, all in favor vote, likewise, by standing.

(The recommendation of Reference Committee was called for again.)

Dr. Black: "That this resolution be referred to Council with the idea of an ad hoc committee being established to study it further."

Dr. Cain: To set the record straight, we are going to San Francisco, uninstructed, just so we vote against this damn bill. (Applause) Not being facetious, I want to know because somewhere along the line we heard something about federal control, was that included in the motion? That is what I want to know?

Dr. Weston: Yes, it was included in the motion.

Dr. Cain: Is that right?

The Chair: That is right.

Dr. Tom Parker: I move that that ad hoc committee be appointed, for it appears from this discussion here many of our doctors don't know that the inroads of the federal government have been multiplied. The federal government for the last several years has been surveying all lands in advance so that they can set up the areas to be developed without the individual owner of the land having any choice with where it goes. That is in the planning stage for the entire United States of America. This is a part of that same program. I think that that ad hoc committee should be appointed to study this and come back at our next convention to inform our medical doctors of the state.

(This was seconded from the floor.)

The Chair: That is the original motion as made by Dr. Black.

Dr. Swift Black (Chrm.): In order to set the



Dr. Wyman King

record straight, several pages back in the minutes will be found the statement "The Committee agrees in principle that federal control should be avoided at all costs." Now, back to the original motion—"That the resolution be referred to Council with the idea of an ad hoc committee being established to study it further.

(Question called for—standing vote taken on this motion and the motion was passed.)

Dr. Swift Black: Gentlemen, the material submitted to this reference committee is in this folder and we have just covered that—so we have very little left to go, actually.

2. A proposal was presented by Dr. James H. Hughes of Lancaster, that a committee be formed to work with the Coaches Association of High Schools, in South Carolina, to study the idea of providing medical care at all scheduled football games, and we so move. (This was seconded by several.)

Dr. William Weston: A doctor in Atlanta presented a paper on this and I think that we in South Carolina are in dire need of coordinating a medical program for our athletes in high schools. This is a wide field for the medical profession to give a lot of help to our athletes.

The Chair: Any further discussion? The motion passed.

Dr. A. R. Johnston (Recognized): Mr. President, I would just like to ask a question, has any plan been made, Dr. Black as to how this was to be implemented?

Dr. Black: No, this was a proposal that a committee be formed to study it.

3. Report of the Mental Health Committee by Dr. George Durst. There were four recommendations:

(1) That the members of the Medical Association be reminded of the 1963 report of this committee. We move the adoption of this portion. (This was seconded, there was no discussion, the vote was taken, motion passed and it was so ordered.)

(2) That intensive study be made by all physicians and county medical societies of the reports of the Governor's Advisory Group on Mental Health Planning. Spectfic response and recommendations are imperative.

We move the adoption of this portion.

The motion passed.

(3) That physicians and County Medical Societies actively participate in the development of Community Mental Health Centers with particular attention toward inclusion into existing general medical facilities.

We move the adoption of this portion.

(4) That the Council and House of Delegates consider ways and means to support, assist and augment the work of the South Carolina Mental Health Commission.

We move the adoption of this portion.

The motion passed.

We recommend the adoption of the report as a whole, and furthermore that the Mental Health Committee and Council continue the watchful and careful study of developments in this particular area. We feel that it is important to keep this in the main stream of medical thought, and we so move.

The motion passed.

4. The Committee on State-Wide Polio Immunization. The Reference Committee is also proud of the accomplishment of the state-wide immunization program with Sabin oral vaccine, and commends the committee for its excellent report. We move its adoption.

The motion passed.

5. The Committee on Industrial Medicine. The reference committee considered this report and since the first portion of this report is already under deliberation in the State Senate it needs no further debate by this body.

The second portion, regarding failure of the Industrial Commission to pay for physiotherapy performed in a private physician's office, under his direct supervision, should be studied further by an appropriate body. The reference committee moves that a committee be appointed or that Council clarify the matter of the 2nd portion at its next meeting.

(This was seconded.)

The Chair: Is there any discussion?

Dr. Frank Owens (Recognized): Mr. President, instead of a committee being appointed—we have an Adjustment Fee Schedule Committee and I wonder if he has in mind that committee?

Dr. Black: We thought that it should be studied or moved on by some appropriate body and since it got so far as getting into a committee report we felt that maybe Council should take action in rechanneling the matter.

The Chair: Is there any further discussion. The motion passed.

6. On the resolution regarding the indictment of tobacco as a cause of respiratory cancer, presented by Dr. William Weston, Jr., of Columbia, the reference committee feels that such research is already being more adequately handled at already established research centers and we recommend that this resolution be not adopted. We so move.

The motion passed.

7. Special Committee on School Health. The recommendations of the Committee were:

(1) That the program be continued and that the membership be appointed on a staggered or overlapping basis, and we so move.

The motion passed.

(2) That the Chairman shall have served as a member of the committee for at least two years before being appointed as such. We so move.

The motion passed.

(3) That the present membership, consisting of six pediatricians be enlarged to include, in addition, a general practitioner, an ophthalmologist, and an otorhinolaryngologist. We so move.

The motion passed.

(4) The establishment of a functioning school health committee as outlined in the report published in the Journal. We so move. The motion carried.

(5) It was further recommended that the Special Committee on School Health meet at least once yearly with the State Joint Health and Education Committee. The joint committee is composed of members of the Department of Education, Department of Health, State Mental Health Commission and State School Finance Commission. We so move. The motion passed.

(7) It was further recommended that a physician through local school health committees, plan with school and health department personnel for preschool clinics and for medical examinations of medically indigent children, and for correction of abnormalities on any grade level when significant deviations from normal are observed by the teachers or school nurses. We so move. The motion passed.

(8) The committee recommended that periodic medical and dental examinations of pupils be made at least three times during the twelve school years, probably during the fourth, seventh and tenth grades. We so move. The motion passed.

(9) The committee recommends that physical examinations be made of pupils on any grade level prior to participation in strenuous physical activities, such as physical fitness tests or athletic sports. We so move. The motion passed.

The reference committee moves the adoption of the report as a whole, as amended. The motion passed.

The Chair: Thank you Dr. Black.

Dr. Black: 8. Public Health Information Committee. The Reference Committee commends the Public Health Information Committee for its excellent work and moves the acceptance of the report as a whole. The motion passed.

9. The Annual Report of the Executive Committee of the South Carolina State Board of Health, presented by Dr. W. R. Wallace, Chairman, as printed in the Journal. The Reference Committee commends the Executive Committee of the State Board of Health for its excellent work and moves the acceptance of the report as a whole. The motion passed.

10. Committee on Infant and Child Health was previously handled by the Legislation Committee and Public Relations.

11. Advisory Committee to the Crippled Childrens' Society. The Reference Committee commends the committee for its excellent work and moves that this Committee be continued. The motion passed.

12. Committee on Cancer. There were no problems presented to this committee, and therefore it did not function. However, we move the continuance of the committee. (Passed)

There was no report to be considered on Rural Health and Maternal Health. We move the continuance of these Committees. (Passed)

The reference committee recognizes the invaluable services of Mrs. Amelia Wallace, who assisted in the preparation of this report.

We appreciate the opportunity of having served in this capacity and move the adoption of the entire report. (Passed)

The Chair: Thank you Dr. Black.

I would like to move that the house express its appreciation for the untiring efforts, and sacrifice of this committee for its prolonged work in giving us this report.

Dr. Robert Wilson

The Chair: We will now have the report of the Reference Committee on Miscellaneous Business, Dr. William H. Prioleau, Chairman.

Dr. Prioleau, Chairman: Mr. President, members of the House of Delegates, most of the reports will be short and I think can be received as information. There may be some question as to whether or not one or two of these reports have been previously considered.

1. The Committee on Emergency Medical Care—did I hear this previously reported? It was checked on our list also. Anyway we commend that report which was made by Dr. Solomon. We commend the committee for their interest and activity and make a motion that it be received as information as published in the Journal, with the supplementary report by Dr. Solomon. (Passed)

2. Special Committee concerning relationship of the South Carolina Medical Association and the South Carolina Medical College, and also to study medical education and state agencies having medical advisory committees. That committee gave a very limited report but very much to the point stating that they saw no purpose in establishing a committee of the S. C. Medical Association to advise the Medical College in the field of undergraduate medical education.

Now, I move the acceptance of that report. (Passed)

I only mention that that Committee does not make any comment on the question of state agencies, apparently it was too broad a subject and they had nothing pertinent.

Dr. Martin M. Teague: I believe the reference to state agencies had been settled last year and only the matter of an Advisory Committee to the Medical College was left for this year's report.

Dr. Prioleau: Thank you, Dr. Teague.

The Chair: That is correct.

3. The next is a report of the Committee on Historical Medicine. The reference Committee commends Dr. Waring on his book and approves of his suggestion that any proceeds from the sale of the book be applied towards the second volume. We move the adoption of that report. (Passed)

4. The Committee on AMA-ERF, reported by Dr. Joel Wyman. We commend that committee for their interest and activities and make a motion that that report be received as information. (Passed)

5. Now, the committee on Membership, on increasing the membership of the State Association, in other words getting in those physicians who are nonmembers. This committee has done a great deal of work and we recommend that this committee be continued for another year with the idea of exploring different types of memberships, which may make it of interest to the present non-members to become members of the Association. I move the adoption of that report. (Passed)

6. The committee on Post Graduate Medical Education by Dr. William A. Klauber. They held three meetings and their recommendations are as follows: In brief they state that the subject should be approached gradually. They recommend specifically

(1) Short "in residence" refresher courses under the direction of the Medical College with such guest faculty as they see fit. And, of course, refresher courses are of short duration and are given in these three fields—radiology, anesthesiology and electrocardiology by the Department of Medicine.



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(2) They further advise that their committee be enlarged to include one or more general practitioners.

(3) They further advise that they continue to expand the field of educational TV.

We make a motion that that report be adopted and commend the committee. (Passed)

7. The Committee on Medical Examiners and Coroners.

That report was given by Dr. Pope, but prepared originally by Dr. Dreskin, who was not present. This committee recommends setting up facilities in the way of a medical examiner in the way of laboratories and with a Chief Medical Examiner, who may appoint other medical examiners elsewhere in the state. This committee has done a great deal of work with the Bar Association. We move the continuation of that committee and we move that that report be adopted. (Seconded)

The Chair: Is there a discussion?

Dr. William Weston, Jr.: (Recognized) Does that mean we are authorized to go ahead and get the bill passed in the Legislature?

Dr. Prioleau: Yes, this Reference Committee feels that that should be the case, approval to proceed with their recommendation as published.

The Chair: The Chair will rule that that is the case but that the matter should also be referred to the Committee on Legislation for joint action.

Is there any further discussion? (Passed)

Dr. Prioleau: 8. Under the heading of resolutions, a resolution has been offered by the South Carolina Chapter of the American Academy of General Practice, and in effect it is in accord with the AMA resolution recently made and the purposes to expedite and implement that resolution.

In brief, it is that the South Carolina Medical Association be apprised of problems concerning the supply of general practitioners, and furthermore that they take what measures they can to correct it, and furthermore that Council report back to the House of Delegates in 1965 on what progress has been made.

I move the adoption of that resolution. (Passed)

9. The next is a report by Dr. Jowers—I don't have the name of that committee—it is concerning nursing problems (State Board of Nursing Examiners). The report was given in detail and we move the adoption of that report as presented. (Seconded)

The Chair: That was the Report of the State Board of Nursing Examiners. Is there any discussion? (Passed)

Dr. Prioleau: 10. There was a resolution proposed by Dr. Arthur L. Rivers. It was short, so I shall read it."Resolved that there be established a Standing Committee of the South Carolina Medical Association for review of professional and economic policies and practices of hospitals and of state institutions and agencies whose work deals with the practice of medicine, with regard to their being in the best interest of medical care; the Committee to consist of five members appointed by Council in such a manner that one member retires each year. No member may serve more than two consecutive terms."

The reference committee Dr. John E. Holler, Dr. J. H. Cutchin, Dr. A. G. Brown, Dr. W. W. Simmons and myself approved of that unanimously and we move its adoption. (Passed)

Dr. Prioleau: I now move the adoption of the report, as a whole, I don't think there were any amendments. (Passed)

The Chair: Thank you very much, Dr. Prioleau.

There is one more Reference Committee report, Reports of Council and Officers, Dr. Parker Jones, Chairman.

Dr. H. Parker Jones, Chairman: This committee met with all members present. There were a number of matters referred to this committee, we considered some rather superficially, some required more thought.

First was the matter of the Reports of officers. I would like to say that the committee commends the officers of the Association for their diligence and we appreciate their reports and their efforts put forward for the work of the society.

I will present each report and ask for its adoption, without further comment.

The reports of the President, President-Elect, Secretary, Treasurer, Executive Secretary, Delegates to the AMA, Editor of the Journal, Advisory Committee to the Woman's Auxiliary and the Committee on Selective Service were then adopted.

The Committee on Scientific Program, we have a lot of praise and thanks for the program that seems to be in store for the rest of the session and move that this report be accepted as received. (Passed)

Before recommending the acceptance of the report of the State Board of Medical Examiners, we wish to point out that the report made to us was not the same as that presented on the floor yesterday afternoon. We recommend the acceptance of the report as presented to our committee. (Seconded)

The Chair: Is there any discussion?

Dr. R. M. Anderson: What was the difference?

Dr. Jones: Shall I read the report as presented to the committee? (The difference was what was requested.)

Well, briefly the report as presented to the committee or the report of the activities of the State Board of Medical Examiners—in addition, we felt that when the report was made there were some comments made concerning the personal achievement or the achievements of some of the members of that committee, which was not included in the printed report and the Reference Committee did not wish to have it felt that we endorsed any comments made in regard to achievements of a member of that committee, personally.

The Chair: Is there any further discussion? (Passed)

Dr. Jones: There were three matters in the Report of Council referred to our committee. I will present these matters separately.

First, it is recommended that the report of the Committee on Tetanus Immunization be adopted as presented. (Passed)

I might comment that the Committee did not have any way of implementing this and it was assumed that the Committee on Tetanus Immunization would be continued to carry out the work that it had recommended.

Second, in regard to a request by Dr. McKee for advice in the matter of establishment of a section of Pathology within the state Medical Association, our committee refers the matter to the House of Delegates with the recommendation that a section of Pathology not be established within the Association. (Seconded)

The Chair: Is there any discussion? The Chair will rule that does not preclude the pathologists from getting together in any fashion that they may see fit.

Dr. Jones, Chairman: We felt like it would make too much piece-meal of the scientific program if we tried to break it up into sections at this time.

The Chair: Is there further discussion. (Passed)

Dr. Jones: The third, in regard to the matter of purchase of a specific property in Columbia as headquarters for the State organization—this committee does not concur in the recommendation of Council that this property be purchased. The committee presents this matter to the House of Delegates with the recommendation that authority to purchase this

property not be approved at this time. (Seconded)

The Chair: Is there discussion?

Dr. O. B. Mayer (Recognized by The Chair): Mr. President, I would like to make a few remarks to give the House of Delegates a little background about this matter. First of all, the committee was appointed by Council to look into the appropriate site for a permanent home. The Committee reported to the Council and it was approved and passed on to the Reference Committee. It is obvious that the delegates are unaware of the benefits that could accrue from owning a permanent home but until such time as the entire membership is aware of these benefits and feels a desire and a pride in owning a home, I feel it should not be undertaken by any means. The fact that the committee was fortunate enough to find a piece of property that presented a good buy, that was located near the capitol, and had many advantages is entirely secondary. And I hope that each of you will give this matter thought. Many of the states have already formed permanent homes; they have developed a sense of pride because their profile has changed before the public and I believe that you will find the efficiency of our operations would give you a sense of pride and I hope in years to come that this may be accomplished, but now is not the time.

The Chair: Thank you, Dr. Mayer.

Dr. William Weston, Jr.: I have a question? Was this reiected because of their consideration of the particular piece of property or was it rejected with the idea that it was going to be in Columbia?

Dr. Jones: I don't believe there was any one specific factor that led the committee to make his decision not to concur in this resolution. The facts that you mentioned were brought up—we are not real estate appraisers, but it was felt that at the present time, (and that was the wording that "it be not entered into at the present time") from the facts presented to the committee that we could not concur in the resolution to purchase the property. If there are any specific questions, I will try to answer them, but that is about as general as I know.

The Chair: Is there further discussion? If not, the motion of the committee to disapprove the purchase of this property at this time is in order. (Passed)

Dr. Jones: Mr. President, that concludes the report of our Reference Committee on Reports of Council and Officers and I move adoption of the entire report.

The Chair: The Chair would like to call the attention of the House to the exceptionally able reference committee chairmen. I will convey to them my own personal thanks as well as the thanks of the House of Delegates for a well done job this morning.

Dr. Thomas R. Gaines: Mr. President, I believe that the House would like to go on record in extending thanks to the committee that worked so hard and faithfully on the matter of securing a permanent home. It entailed a lot of work, and I move the House of Delegates go on record as extending our thanks to them.

The Chair: The motion is to extend to Dr. Mayer's Committee the sincere thanks of the House of Delegates for their work in this regard. (The motion passed.)

(To Be Continued)

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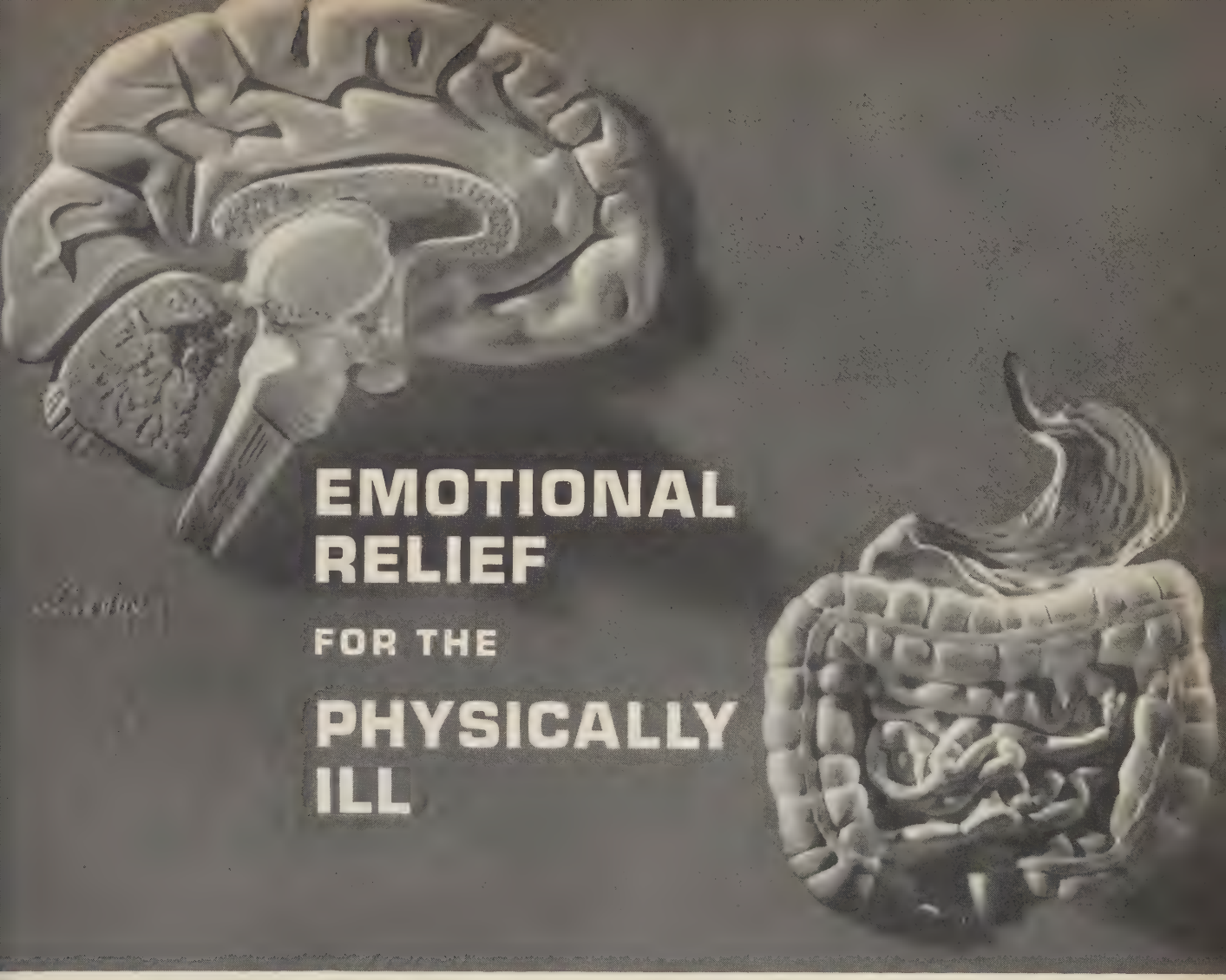
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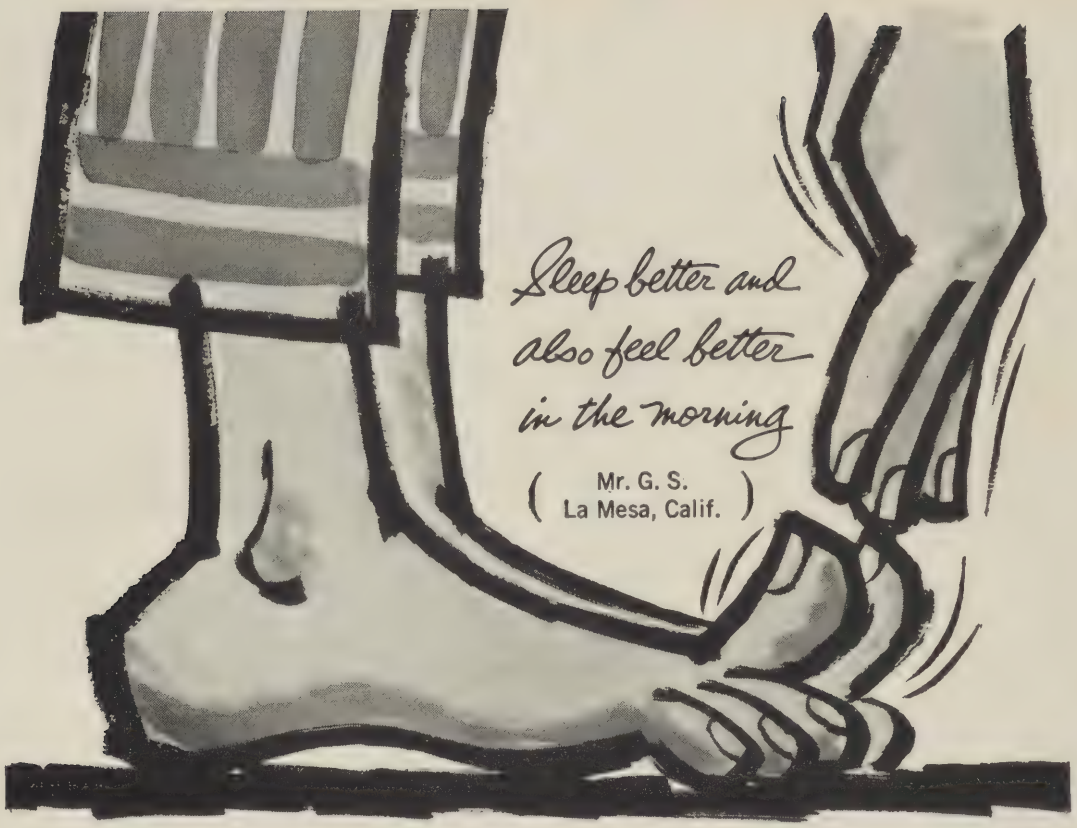
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Of 1,028 patients with confirmed respiratory infections... 954 or 92.8% were treated successfully with Signemycin®

Note:
Hammerl* selected his patients for treatment with Signemycin on the basis of demonstrated bacteriological resistance to other antibiotics or failure of previous therapy. Of 100 patients with various respiratory tract infections, 95 responded to Signemycin. Pathogens isolated included staphylococci and *Diplococcus pneumoniae*.

*Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958.

Condition	No. of Patients	No. Cured with Signemycin
Abscess, pulmonary	17	16
Bronchiectasis	19	13
Bronchitis	286	267
Bronchopneumonia	192	179
Empyema	12	11
Pneumonia, lobar	150	146
Pneumonia, other febrile	160	150
Various infected pneumopathies	192	172
Totals	1,028	954 (92.8%)

consistently effective...often when others fail

Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

Brief Summary and Bibliography follow.

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Average adult dose: 1, or if needed, 2 tablets three times daily. *Precautions:* Observe patients periodically for increased intraocular pressure and barbiturate habituation or addiction. Caution drivers against possible drowsiness. *Side effects:* Dehydrocholic acid may cause transitory diarrhea; belladonna—blurred vision, dry mouth. *Contraindications:* Biliary tract obstruction, acute hepatitis, glaucoma, and prostatic hyperplasia. *Available through your regular supplier:* DECHOLIN-BB, bottles of 100 tablets. 72664

Ames Company, Inc., Elkhart, Indiana. AMES



Of 507 patients with confirmed ear, nose and throat infections... 465 or 91.7% were treated successfully with Signemycin®

Note:
Adams,* whose 50 patients included 20 with ENT infections, stated that Signemycin "was particularly valuable in infections that did not respond to other antimicrobial agents, and in patients to whom penicillin could not be given." All his cases responded within five days; in most patients, all signs of infection disappeared in three days.

*Adams, J.: J. Tenn. Med. Ass. 50:446, Nov., 1957.

Condition	No. of Patients	No. Cured with Signemycin
Otitis media	90	86
Pharyngitis and laryngitis	162	148
Sinusitis	68	55
Tonsillitis and peritonsillitis	163	153
Various	24	23
Totals	507	465 (91.7%)

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Of 1,021 children with various confirmed infections... 950 or 93.0% were treated successfully with Signemycin®

Note:
The effectiveness of Signemycin was demonstrated by Chattas and his co-workers* who administered Signemycin to 30 children with serious staphylococcal infections resistant to commonly used antibiotics. Only one failed to respond. In each case the use of this drug was indicated by antibiogram. Those children treated with a nonselected antibiotic—for comparative purposes—took three times longer to recover.

Chattas, A. et al.: Antibiot. Med. 7:300, May, 1960.

Condition	No. of Patients	No. Cured with Signemycin
Eye, ear, nose, throat infections	368	343
Respiratory infections	369	346
Gastrointestinal infections	42	30
Skin and soft-tissue infections	38	37
Deep-seated or generalized infections	47	44
Various conditions	157	150
Totals	1,021	950 (93.0%)

consistently effective...often when others fail

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Signemycin is also available as half-strength Capsules, preconstituted raspberry-flavored Syrup and Pediatric Drops

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Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

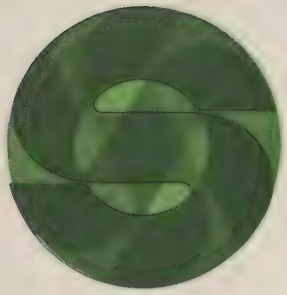
Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

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Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Cured with Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

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Effective in peptic ulcer, intestinal colic, ileitis, esophageal spasm, spastic colon, alcohol-induced G.I. upsets, gastric hypermotility and anxiety neurosis with G.I. symptoms. Should be used as adjunct to other measures.

Side Effects (due to tridihexethyl chloride): dry mouth, blurring of vision, constipation.

Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention.

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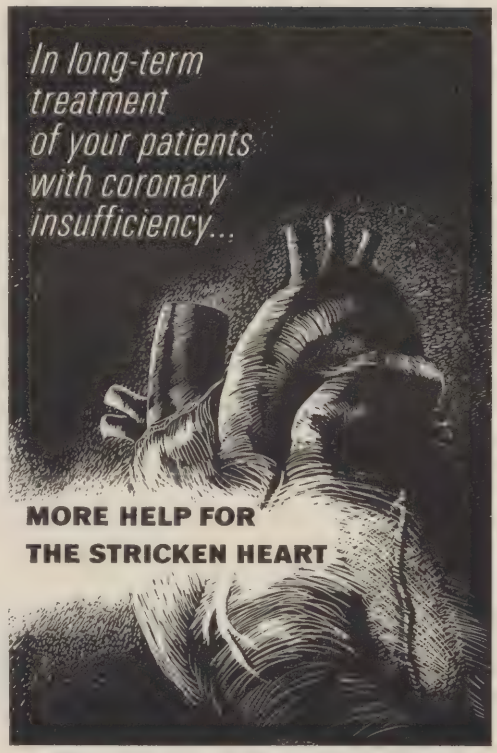
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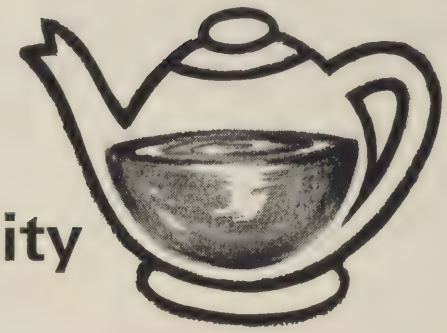
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*Clinical report on file, Medical Department, A. H. Robins Co., Inc.

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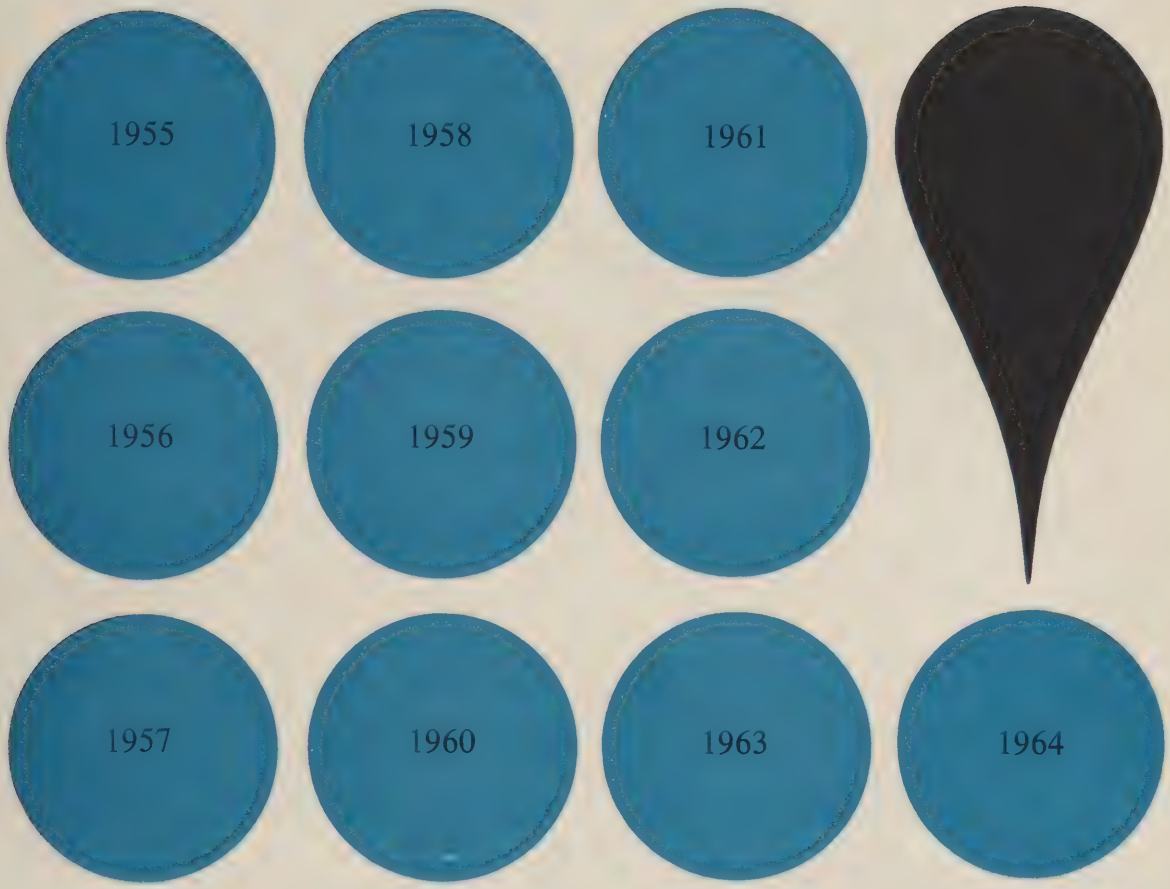
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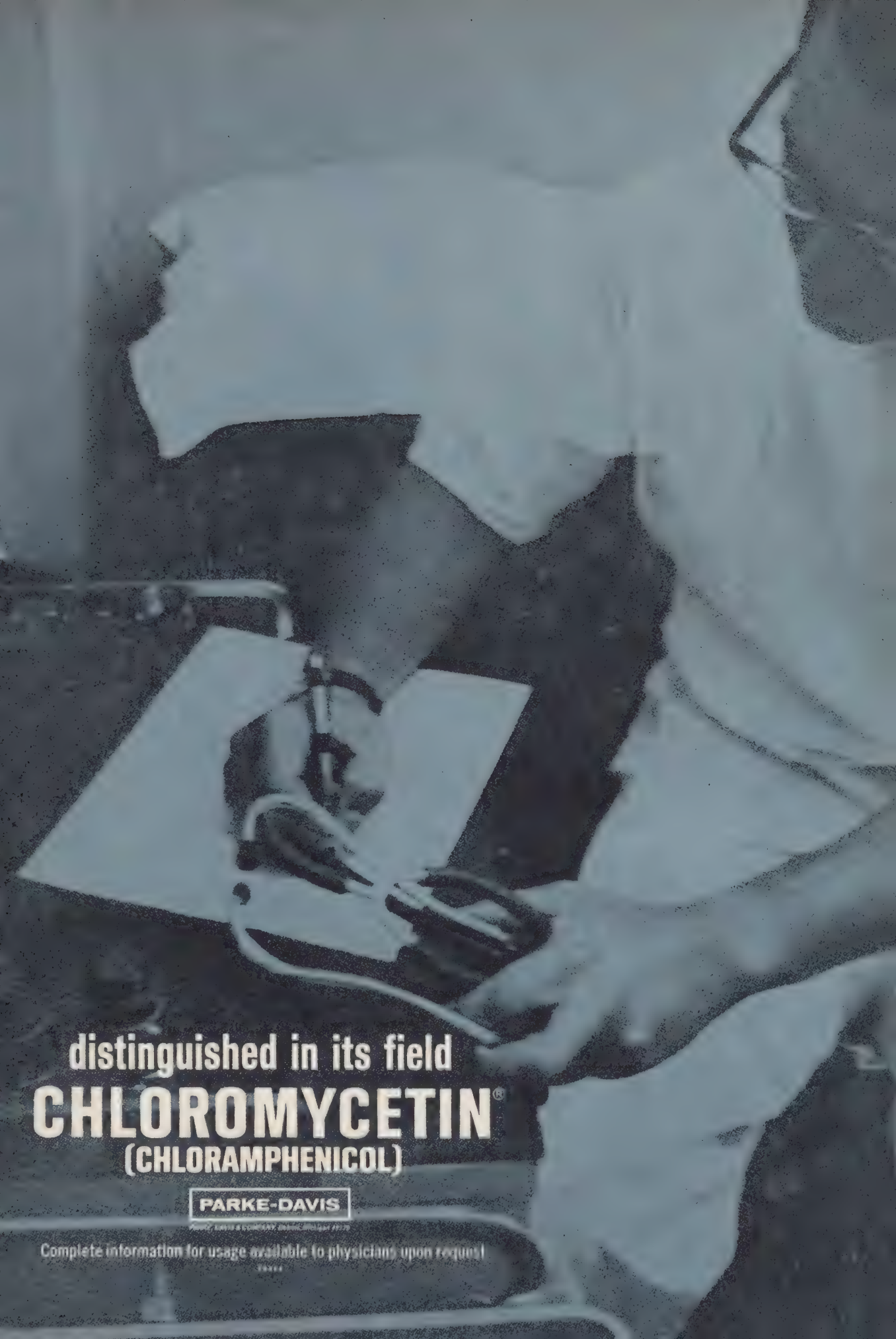
Contraindications: Hyperexcitability, hyperthyroidism.

Before prescribing, see SK&F Product Prescribing Information.

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1. Dorfman, W., and Johnson, D.: *Overweight Is Curable*, New York, The Macmillan Company, 1948, p. 16.

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Cautions—Occasional side effects, often dose-related, are drowsiness, ataxia, minor skin rashes, menstrual irregularities, nausea and constipation. Paradoxical reactions may occasionally occur in psychiatric patients. Individual maintenance dosages should be determined. Advise patients against possibly hazardous procedures until maintenance dosage is established. Though compatible with most drugs, use care in combining with other psychotropics, particularly MAO inhibitors or phenothiazines; warn patients of possible combined effects with alcohol. Observe usual precautions in impaired renal or hepatic function, and in long-term treatment.

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Length—Short articles of about 2,500 words (about 8 typewritten pages, double spaced) are preferred. Longer articles ordinarily will defer to the shorter ones in schedule of publication.

Manuscripts— Manuscripts should be typewritten, double spaced, and the original and a carbon copy submitted.

Illustrations—Ordinarily publication of 4 small illustrations or the equivalent accompanying an article will be paid for by The Journal. Any number beyond this must be paid for by the author except under unusual conditions. Illustrations should be sent as glossy prints or graphs in black ink with lettering large enough to show after reduction.

References—Should conform to the following order: surname and initials of author, title of article in small letters, name of periodical, with volume, page, month, day of the month if weekly, and year—e.g.: Lee, G. S.: The heart rhythm following therapy with digitalis, Arch Int Med 44:554, Dec. 1942. They should be listed numerically in order of appearance in the text. Standard abbreviations for journals should be used. Note that periods are not used with these abbreviations as indicated by the Index Medicus. Other abbreviations should also be standard—e. g. mg, ml, Gm.

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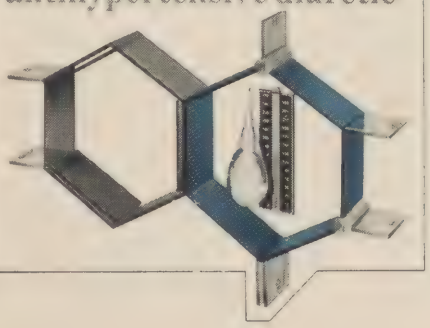
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CONTRAINDICATION: Anuria.

1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

2. Schwartz, M.: Office Evaluation of a New Diuretic in Patients with Hypertensive Diseases. Scientific Exhibit Presented at the Clinical Meeting of the American Medical Association, Los Angeles, California, Nov. 25-28, 1962.

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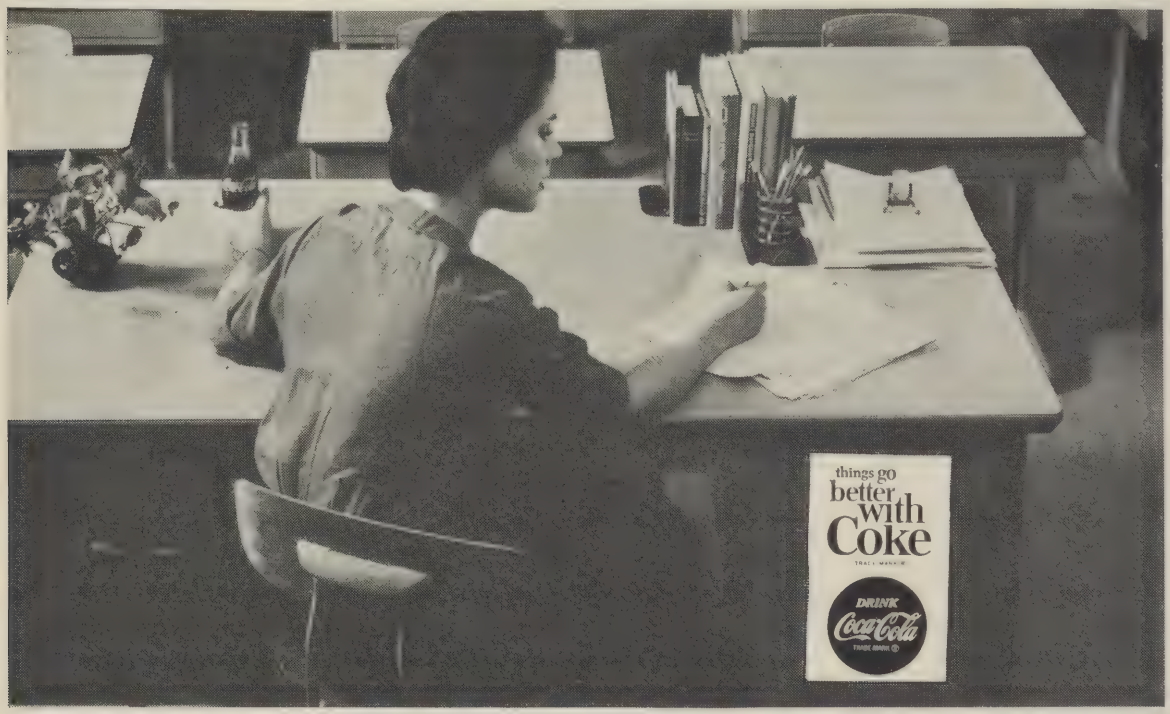
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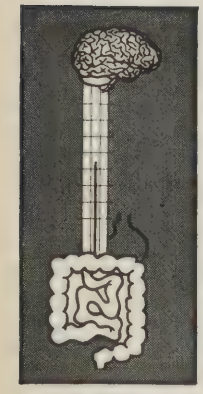
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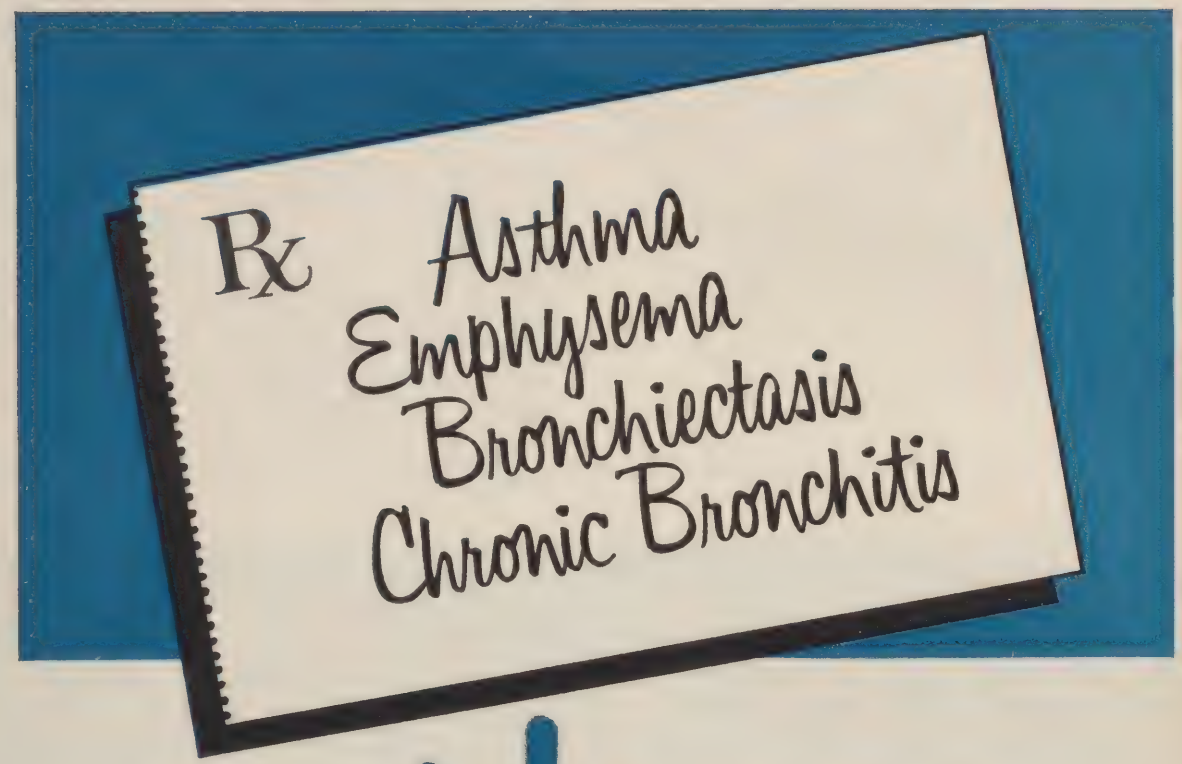
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The Journal
of the
South Carolina Medical Association

VOLUME 60 October, 1964 NUMBER 10

NEGLECTED OR PHYSICALLY ABUSED CHILDREN

A Review

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Within the past few years there has been an increased awareness within medical circles of a major problem involving the willful or non-willful neglect or physical abuse of children. This neglect may vary all the way from the passive willful or non-willful withholding of food, clothing, shelter and parental love to the point of fatal starvation to the active, aggressive willful administration of beatings to the point of death as a result of severe, repeated physical abuse.

In instances of physical abuse the typical x-ray findings consisting of multiple fractures of bones accompanied by subdural hematoma were first described by Caffey[1] in 1946. In 1953 Silverman[2] reported additional cases and ascribed the lesions to trauma which was either not recognized or not admitted. In 1955 Woolley[3] first indicated that inflicted injury was the primary cause of many of these cases.

In a recent nationwide search of the files of 71 hospitals and 77 district attorneys' offices for a one year period for evidence of physical abuse, Kempe[4] found that 749 children had suffered from what he has called "the battered child syndrome." Of the 749 cases, 78 (10.4%) died and 114 (15.2%) suffered permanent brain damage. Regretfully, in only one third of these cases was proper medical diagnosis followed by some sort of legal action.

Adelson[5] has recently pointed out that children without a single physical injury may be just as much the victim of parental abuse as those who suffer repeated fractures and subdural hematomas. Reporting five infant homicides by starvation in the past five years, Adelson points out that all of the victims were less than nine months old, none had any food in the stomach and all were markedly underweight for their respective ages. Legal action was taken in all of the cases reported.

The incidence of death from starvation is difficult to arrive at since most of these cases carry multiple anatomical diagnoses in addition to the respectable sounding one of "malnutrition." In reviewing a small series of autopsy reports (36) which included both "private" and "service" type cases accumulated over a 14 year period, this writer found that "malnutrition" was a prominent factor as a cause of death in 15% of the reviewed reports.

Fontana[6] has pointed out that the maltreated child may present no obvious evidence of being "battered" but may show multiple minor evidences of physical, nutritional and emotional deprivation. Such children demand the most critical of diagnostic acumen in order to be identified by the physician, who, once suspecting physical or nutritional abuse, is obliged to take whatever measures are available to prevent further neglect

which, if allowed to go unchecked, may proceed to irreversible starvation, permanent crippling or death.

Case Reports

The two case reports which follow are rather typical of children starved or physically abused to death.

Case 1. A five month old colored male was admitted to the hospital because of dehydration and malnutrition. The mother innocently stated that the child had been well until the day of admission when he suddenly became ill and refused his bottle.

Physical examination revealed a critically ill infant who was severely dehydrated and comatose. Although 5 months old he weighed only 6 lb. 8 oz. (39% of weight expected for his age). The pulse was 70 and respirations were slow at 5 or 6 per minute. The mucous membranes were dry and crusted. The skin was dry, loose and had very poor turgor. The abdomen was soft and flat. The heart and lungs were not remarkable.

The infant was given stimulants and placed in an oxygen tent. He was later given fluids, plasma and prophylactic antibiotics. He expired 13 hours after admission.

A post-mortem examination was performed and disclosed the following: the head, thorax and lower extremities were emaciated; the abdomen was distended with gas; no appreciable subcutaneous fat was observed; there was no food in the stomach or intestines; a "small soft" thymus gland was present. The pathological diagnosis was "malnutrition."

Case 2. A one year old white female was admitted to the hospital with the complaint of "difficult breathing" and "abdominal swelling." X-ray studies revealed marked changes in the diaphyseal and metaphyseal regions of the long bones and a diffuse periosteal reaction in the shafts of many of the ribs. The preliminary clinical impression was "chronically traumatized scurvy."

Neighbors of the family reported parental trauma and this was the working diagnosis at the time of discharge from the hospital. The Juvenile Court was asked to evaluate the family, found the father "rude and uncommunicative" but was unable to prove maltreatment.

Five months later a physician was called to the home and found the patient dead. A post-mortem examination was performed by the coroner's physician which revealed both fresh and old lacerations on various parts of the body, subdural hematoma and an area of hemorrhage about the capsule of the left kidney. Post-mortem x-ray films revealed the previously mentioned bone changes in various stages of healing and, in addition, a fresh fracture of the left tibial shaft.

The parents were arrested and charged with murder. Psychiatric examination revealed that the parents were "not insane." They later pleaded guilty of murder and were sentenced to the State Penitentiary.

Clinical Manifestations

The physical appearance of the malnourished child almost at once refutes the parents story of sudden onset of illness. Adelson has quite aptly pointed out that "the key which opens the door to the correct diagnosis of neglect" by starvation is the glaring discrepancy between the story of the parents and the physical evidence of prolonged deprivation of food and water.

All of Adelson's five patients were born of uneventful labors and deliveries and all weighed five or more pounds before going home. None had been seen by a physician or visiting nurse for at least three months prior to death and two of the victims had had no medical care since birth. All were less than 9 months old when they died, "indicating the vulnerability of the organism to malnutrition at this age of rapid growth." In addition, none had any food in the stomach, each had a small thymus weighing less than five grams (normal 15 to 20 grams) and all suffered from severe weight loss and weighed only 30 to 45% of that expected for their respective ages.

Two of the fatally starved-to-death infants were dead on arrival at the hospital and the other three died within 7 hours after they were first seen in the emergency ward. The clinical impression in all cases was severe malnutrition; all were subjected to autopsy at the coroner's office where the clinical impression was confirmed; all deaths were attributed to starvation as a result of prolonged neglect. It was felt by Adelson that all of these infants would have survived had they been given proper amounts of food, water and loving care before the condition had become irreversible.

The malnourished infant who fails to thrive as the result of starvation must be distinguished from the infant whose failure to thrive is associated with such diseases as severe congenital anomalies of the heart or

kidneys, congenital or acquired hypothyroidism, congenital pyloric stenosis, cystic fibrosis of the pancreas and the various "celiac" syndromes.

The physically abused child frequently presents surface lesions such as scratches, bruises, laceration and burns as evidence of external trauma and soft tissue swellings of the head, trunk or extremities as evidence of such internal lesions as subdural hematoma, fractures, dislocations or rupture of a viscus. Alarmingly suspicious is the presence of both fresh and old surface lesions in various stages of healing. Inability to move an extremity is suggestive of fracture or dislocation in the affected limb.

Subdural hematoma in association with multiple skeletal fractures has been noted by Caffey in many of these physically abused children. Kempe has pointed out that subdural hematoma, with or without fracture of the skull or long bones, may be expected in over 15% of all physically abused children. A history of vomiting and convulsions accompanied by the presence of retinal or subhyaloid hemorrhages should alert one to the diagnosis of subdural hematoma. As O'Doherty[7] has recently pointed out, it is most important to diagnose subdural hematoma promptly since it is a treatable lesion which, in contrast with the others, cannot be expected to clear on its own and if allowed to progress untreated will contribute appreciably to mortality or impairment of intellectual development.

The physically abused child is one of the few conditions in medicine where x-ray films can be read with complete disregard for the clinical history, which is frequently misleading. As Kempe has so succinctly stated, "the bones tell a story the child is too young or too frightened to tell." Pathognomonic of the battered child is the x-ray finding of both new and old fractures in various stages of repair in the same subject. If no fractures or dislocations are noted on initial x-ray survey, repeated x-ray study in a week or so will usually show evidence of early repair in a sufficiently traumatized bone.

The x-ray films in these cases usually show any or all of three characteristic changes. First of all they may show metaphyseal fragmentation secondary to pulling or twisting of the afflicted extremity with "squaring" of the long bones secondary to new bone formation about the metaphyseal fragments. Secondly, there may be periosteal elevation secondary to hemorrhage beneath the area where the periosteum has became traumatically detached. This is followed in a week or so by deposition of new bone in and beneath the periosteum. The new bone eventually becomes incorporated in the shaft of the healing bone but the shaft itself remains thickened for a number of months after the trauma has occurred. Lastly, there may be epiphyseal separation and periosteal shearing as the result of traction and torsion of the affected limb. The appearance of epiphyseal separation might possibly be confused for a traumatic dislocation but this type of injury actually suggests the diagnosis of physical abuse since infants and young children seldom if ever suffer traumatic dislocations.

Griffiths[8] points out that it is "characteristic that the child makes a good and rapid recovery while in the hospital" and that "no new lesions occur" while the child is in the hospital. These observations in themselves, are strong points in favor of a diagnosis of physical abuse.

In the differential diagnosis one must consider such conditions as fractures associated with prolonged labor and difficult delivery, skeletal changes associated with congenital syphilis, osteogenesis imperfecta, infantile cortical hyperostosis, congenital indifference to pain, and scurvy. It is now believed that many cases of physical abuse in the past were erroneously diagnosed as scurvy and Griffiths is "convinced that many children have been exposed to the hazards of repeated inflicted injury because of the erroneous diagnosis of scurvy in these cases."

Social Manifestations

The neglected, malnourished infant and the physically abused, battered child are almost completely at the mercy of the family with

which they reside. The starved infant is too young to help himself and eventually becomes too weak to cry whereas the physically abused child is either unable to tell his story or too fearful to relate it.

A striking, almost diagnostic feature of history-taking in cases of neglect and physical abuse is the attitude of "complete innocence" which is conveyed by the parents to the examining physician. These parents seldom admit that any neglect or physical abuse has been inflicted upon the child and frequently there is a complete denial of any knowledge of any type of inflicted injury. Ordinary parents, by contrast, would be most upset to see a child in such a condition and would be in a state of agitation to discover the how, when, where and why for such a state of affairs.

The histories furnished by the mothers of Adelson's five fatally starved infants were all strikingly similar and were completely refuted by the clinical appearance and post-mortem findings. Most gave statements such as "the child was well up to the last day or two." Investigation of the home situations, however, disclosed long periods of willful neglect and complete disregard for the condition of the child together with unwillingness and failure to seek readily available medical care.

Merrell,[9] reporting an agency study conducted by The Massachusetts Society for the Prevention of Cruelty to Children concerning physical abuse of children in 1960, found that the abusing families had many features in common. The majority had lived in the same community for years, were self supporting, had few outside interests besides their church and were not fully accepted within their communities. Ninety percent of these families had "serious social problems" and in about 50% of these families premarital conception had occurred. It was felt that these families had many problems and that these problems had multiplied and intensified by the time physical abuse first occurred.

The study revealed that in 86% of the cases the parents were the abusing adults and that abuse was committed about equally by the father and the mother. This probably reflects the fact that it was the parents who had both the predisposition and the opportunity to inflict unobstructed abuse within the home.

The Merrell report found that the personalities of the abusing parents fell into three general groups. First was a group of parents characterized as being hostile and aggressive as though constantly angry at someone or something. Second was a group noted to be rigid, compulsive and lacking in warmth and pliability in their thoughts and beliefs. The third group was characterized as being overly passive, dependent and unassuming. Many of these were immature and uncertain as to whether they wanted to be married, have children or a home of their own. The majority of these abusing parents showed no outward evidence of "nervousness or psychosis" and had had no major difficulties with the law.

The study discovered that almost all of the child victims were free of physical disability, mental deficiency and psychosis. All showed a seriously impaired relationship with the abusing parent but a good ability to react appropriately to others either within or outside the home. The behavior of these children did not warrant the abuse heaped upon them. Characteristically only one child in the family was singled out for abusive treatment and once the abuse began it tended to become repetitious and progressively more severe.

Psychiatric Implications

Studies concerning the parents' feelings, thoughts and motivations leading to neglect or physical abuse are meager.

In respect to neglected, starved children it has been noted that in some instances the malnutrition is associated with the fact that the parent is so physically or intellectually handicapped or so uninformed or misinformed that he simply is unable to do better. In other instances the neglectful parent shows a lack of feeling, tone and affect toward the starved child who is related to as though he were a stick of wood. At other

times one observes instances where the child is deliberately neglected and starved so that he can be used as a decoy by the parents in order to prey upon the sympathies of sensitive persons and organizations with the hope that money or other valuable gifts will be forthcoming.

From the data available it appears that many physically abusive parents have a defect in character development which allows aggressive impulses to be expressed too freely. Observations tend to indicate that early life experiences of the abusive parent which have resulted in unresolved emotional need or conflict are involved in the physical abuse inflicted upon the child. The abusive action, then, is triggered by the mere presence of the child within the environment and his unwitting and unavoidable involvement in the parents' unresolved difficulties.

In discussing the psychiatric implications of the physically abused child in the Massachusetts study, Kaufman[10] felt that if one could approach the abusing parent in terms of unfulfilled needs and sense of unresolved hostility one could sometimes begin to alleviate some of the pathological need to handle anxiety in such a primitive way as by attacking the child. He also found that many of these people feared close relationships with those who were trying to help them. The use of authority, rather than warmth and friendliness which tended to stir up even more anxiety within the abusive parent, was more readily accepted and more easily handled by the abusive parent. These parents seemed to have failed to achieve a level of development that would enable them to feel guilty for what they had done, so that any attempt to mobilize a feeling of guilt in therapy was doomed to failure.

Kaufman noted that abusive parents characteristically denied their part in the abuse even though it was rather obvious that they had indeed been abusive. In some instances the denial was based on a rather practical fear of reprisals. In other cases the denial was actually a defense of their own personality for they did perceive that to admit to someone else that they had acted in such a violent, destructive, life-threatening way was also to acknowledge to themselves that they were indeed severely disturbed.

Although ideally one attempts to rehabilitate the entire family, in one third of these cases in the Massachusetts study, the danger to the child was so urgent that the child had to be placed elsewhere.

Legal Implications

Schoepfer,[11] in discussing the legal implications in connection with physical abuse of children, has pointed out that voluntary admissions made by parents of their direct relationship to the neglect or trauma at a time prior to when they become involved in a court action are admissable evidence of what occurred, and that these admissions may properly be repeated in court by the physician, nurse, social worker or others to whom the admissions were made. Statements of neighbors, relatives and friends given out of court may be enlightening but are legally defined as hearsay and are not admissable evidence in court. The medical history obtained from the parents, findings on physical examination, laboratory and x-ray studies, and, in cases of death, post-mortem examination reports are also considered good legal evidence of what occurred.

The Massachusetts study of 1962 indicated that while over 30% of neglected or physically abused children had been seen by medical personnel only 9% were referred to appropriate agencies in order to prevent reoccurrences. One explanation for this seems to be that in many instances the diagnosis was missed while in others the physician, though suspicious of neglect or physical abuse, was loathe to believe that parents could indeed be so inhumane. In other cases physicians failed to act because they were uncertain as to what to do or were fearful of making a mistake in diagnosis which, if pursued with vigor, might lead to adverse publicity and an unwelcome law suit for slander. Unfortunately, in many communities there are neither social agencies in existence to investigate nor Family or Juvenile and Domes-

tic Relations Courts to which to petition in behalf of the child and the physician is left with no choice but to swear a warrant personally with the local law enforcement officers or county sheriff in the childs' behalf.

In order to allow the physician more leeway in cases of "suspected" physical abuse the Advisory Committee to the Childrens' Division of the American Humane Association has urged that state legislation be passed making it mandatory to report cases of suspected inflicted injuries upon children. Within the past year the Childrens' Bureau of the Department of Health, Education and Welfare has proposed a model state law for the mandatory reporting by physicians and institutions of certain physical abuse of children. The entire text of the proposed model law appeared in a commentary by Bain[12] in the June 1963 issue of *Pediatrics*.

Principles covered in these suggested mandatory laws for the reporting of "suspected" physical abuse of children include:

(1) That such legislation be called to the attention of medical practitioners and hospital personnel who are involved or who become involved in the care of children.

(2) That medical practitioners or hospital personnel have a mandatory responsibility for reporting all cases of serious physical injury brought to them or coming before them for examination, care or treatment in which they have "reasonable cause to suspect" was incurred by other than accidental means.

(3) That these reports be made to the local social agency, Family or Domestic Relations Court, or designated police authority responsible for the child-protective functions of that community.

(4) That anyone acting in good faith in making of a report or participating in any judicial proceeding resulting from such a report will be immune from any liability, civil or criminal, that might otherwise be incurred or imposed.

(5) That neither the physician-patient privilege nor the husband-wife privilege shall be a ground for excluding evidence regarding a childs' injuries or cause thereof in any judicial proceeding resulting from filing of such a report.

At present 10 states make it mandatory for physicians and institutions to report cases of physical abuse to a designated local authority. The Committee on Infant and Child Health of the South Carolina Medical Association has recommended, through proper channels, that a model law be introduced into the South Carolina legislature which would include provisions for the reporting of willful or non-willful starvation of children as well as physical abuse.

Medical Implications

The incidence of neglect or physical abuse of children is startling and the solution to the problem requires the full effort and cooperation of the medical, social service and legal organizations of each community. In the past many practitioners were either unaware or reluctant to believe that parents could be so inhumane to their children. Recent recognition of neglect through starvation or physical abuse as distinct medical entities has helped medical practitioners feel more secure in arriving at a firm diagnosis in these cases.

The infant neglected through starvation characteristically presents a number of distinct, positive findings. The infant is often under 9 months of age, frequently is presented with a story of sudden refusal to eat, usually shows a mere 30 to 45% of the weight expected for his age, is usually severely emaciated and dehydrated in appearance and moribund or near moribund when first brought for medical care. In those who succumb, autopsy reveals a weight of only 30 to 45% of the norm, absence of food in the stomach and intestines, absence of subcutaneous fat stores and a thymus weighing around 5 grams (normal 15 to 20 grams).

The physically abused child usually comes with a number of characteristic positive physical findings and x-ray changes that belie the story of "accidental injury." These children are often brought to the physician out of fear

of impending death. The story offered by the parents is usually that of "falling all the time," "clumsy," or "fell from the bed." Typically the physical examination reveals the presence of both fresh and old surface wounds along with evidence for soft tissue injury of the head, body or extremities. X-ray survey of the child frequently reveals the presence of both fresh and old fractures in various stages of repair. Almost diagnostically, these children develop no new lesions while hospitalized. In many instances one finds evidence of trauma to the extremities in association with subdural hematoma with or without skull fracture.

The physician should admit cases of "suspected" neglect or physical abuse to the hospital for thorough medical study and social investigation. If this is impossible the physician should report the facts of the case to the local police or county sheriff who should take appropriate action to protect the child from further injury or death.

A good medical social worker is frequently the physicians' best ally in helping these children. The social worker is in the position of being able to investigate and integrate the medical, legal and social aspects of each case and can petition the appropriate legal authorities in behalf of the child (friend of the court) for whatever legal action and placement is deemed to be in the child's best interest. Mandatory reporting according to law should relieve even the most reluctant physician of his qualms in calling cases of "suspected" neglect or physical abuse to the attention of designated authorities.

Persons interested in the plight of these children should remember that in many cases the prompt return of the child to the home has resulted in further neglect or abuse leading to further crippling or death. Therefore, in addition to identifying these victims, every effort should be made to insure that the child does not return to an environment which offers even the slightest risk of additional neglect or abuse. Unless adequate provisions are made for the subsequent care of these victims and for the rehabilitation of their neglecting, abusive parents, little in a positive way will have been accomplished. Unfortunately, in many cases the only solution is to remove the child from the life-threatening home by court order, since many of these parents are beyond the reach of present therapeutic measures.

Summary

Cases of neglect through starvation or physical abuse are distinct medical entities and the diagnosis of each is based upon positive clinical and pathological findings.

A law for the mandatory reporting of cases of willful or non-willful neglect through starvation or physical abuse is needed in South Carolina.

It is recommended that every effort be made to identify and, wherever necessary, to remove these neglected or physically abused children from the custody of their inhumane parents before irreversible damage or death occur.

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NORMOBLASTEMIA

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INTRODUCTION

Metastatic involvement of the bone marrow by both malignant and infiltrative disease may present a variety of hematologic abnormalities. A typical finding in myelophthisic anemia (also known as leuco-erythroblastic anemia, myelosclerosis associated with a leukemoid blood picture, myelofibrosis, aleukemic myelosis and many other synonymous designations)[1] is the finding of nucleated red cells in the circulating blood often associated with the presence of immature granulocytes. It has been reported as occurring with a number of diseases including carcinomatosis, tuberculosis, lymphoma, leukemia and polycythemia vera.[2] The presence however of nucleated red cells in the peripheral blood is not sufficient to make the diagnosis since this might occur in other conditions such as infections, heart failure and cerebro-vascular accidents.

The symptomatology of myelophthisic anemia is often poorly defined and dependent on the underlying disease. Anemia may or may not be present[4] and the granulocytic changes can be variable. The differentiation from primary or agnogenic myeloid metaplasia is not difficult as a rule with knowledge of the history, physical findings and bone marrow results. Regardless of the cause, the presence of nucleated red cells in the peripheral blood is a very grave prognostic sign, particularly when due to space occupying lesions of the marrow.[5, 6, 7]

Case 1.

Miss M. R., a 53 year old, white female gave a history of having had intermittent, aching, upper abdominal pain off and on for several years which was associated with some nausea and vomiting and abdominal cramps. Approximately three months prior to her admission to the hospital, she began to complain of progressively severe abdominal pain associated with anorexia and a weight loss amounting to some ten pounds.

Her past history was interesting in that she had had recognized asbestosis with progressive changes on x-ray examination but apparently this had not produced any symptoms of pulmonary insufficiency. Otherwise, the past and family history were within normal limits.

Physical examination on admission revealed a well-developed, well-nourished lady with a blood pressure of 106/64 mm Hg. She was alert and in no acute distress. The skin was of good turgor and color. The pupils were round, regular and equal and reacted to light and on accommodation. Her eyes, ears, nose and throat were not remarkable. No generalized lymphadenopathy was noted. There were bilateral crackling rales scattered throughout both lung fields, more pronounced on the right. The breasts showed a small mass in the upper outer quadrant of the left breast. The abdomen was soft with mild tenderness on the right but no organs nor masses were palpable.

Her original blood studies revealed the hemoglobin to be 12 grams and the white count 10,750 with a normal differential except for the presence of one normoblast per 100 white cells. Urinalysis was completely negative. The platelet count was reported low at 85,000. Repeated studies of her blood prior to the operation showed slight hypochromia and occasional normoblasts. There were no abnormalities of the white cells. The bleeding and clotting times were normal as were the prothrombin time and serum bilirubin. Stools were negative for blood, ova, and parasites. X-ray studies showed fibrotic changes in the lung fields compatible with asbestosis; cholecystitis with cholelithiasis; and a diverticulum in the sigmoid segment of the colon.

On October 1, 1962, she was subjected to cholecystectomy and it was noted that the gall bladder was moderately thick walled and contained approximately 150 small calculi. The cystic duct was small but neither this nor the common duct was obstructed. The liver was described as being finely and coarsely nodular in both lobes. It was felt at the time of operation that the nodularity was somewhat suggestive of hemangiomata or possible cirrhosis. The re-

mainder of the abdominal contents were normal to palpation. There was no free peritoneal fluid. At the completion of the cholecystectomy, the blood pressure fell and was controlled with difficulty and it was felt by the surgeon that there was increased tendency toward bleeding. Following her return to the ward a blood count was done showing a VPC of 25% and hemoglobin of 8 grams. The bleeding time was still two minutes. Because of this, blood transfusion was started and this resulted in the return of the blood pressure to more normal limits. The patient continued however to be somewhat irrational and semicomatose and did not react properly from the anesthesia. An electrocardiogram showed no abnormality. She was given several more units of blood because of the continuing difficulty with her blood pressure but continued to be somewhat stuporous and irrational. A lumbar puncture was entirely normal. In view of this, I was asked to see her and at that time she was obtunded and irrational and slightly jaundiced. She appeared both chronically and acutely ill. Her pallor was moderate but there was evidence of bleeding from her nose and large ecchymoses over her entire body. The blood pressure was 90/50. The previously described mass in the left outer quadrant of the breast was noted but the liver and spleen were not felt although it was difficult to palpate because of the patient's condition. At that time her platelet count was 32,000 and the reticulocyte count 1.2%. The differential showed 33% polys, 25% stabs, 1% juveniles, 3% myelocytes C, 36% lymphocytes, and 2% monocytes, with 2 normoblasts per 100 white cells. An attempt was made to obtain a bone marrow specimen but despite repeated attempts this resulted in a dry tap. The Coombs test was negative.

Her condition continued to deteriorate with increasing stupor and jaundice although she did not develop any fetor hepaticus or liver flap. She was started on steroids with no response. On the day prior to death a tracheostomy was done but despite this she progressively went down hill and expired on October 5, 1962.

An autopsy done on October 5, 1962, seven hours following death revealed obvious jaundice and many ecchymotic areas over the skin. The pertinent findings was the very extensive involvement by tumor cells throughout the lung parenchyma with extensive infiltration of the vessels with tumor cells. Also many areas of fibrosis were noted and asbestos bodies were easily found. The bronchogenic carcinoma spread to the spleen, pancreas, liver, adrenals, ovary and lymph nodes and almost completely replaced the bone marrow. No evidence of metastatic disease was found in the brain.

Case 2.

Mr. W. M. Q., a 64 year old, white, married man had been told two years prior to his death that he had had "prostate trouble" but was relatively asymptomatic until September of 1962. At that time he first noted the onset of nocturia and several weeks later some frequency and urgency with a decrease in the size and force of the urinary stream. On several occasions he had minimal pyuria which cleared with treatment by a urologist. Because of these complaints he was admitted to the Roper Hospital on September 3, 1962. He gave the added history that he had been having some anorexia and had lost fifteen to twenty pounds in weight over the period of the preceding six to eight months.

On physical examination he was a well-developed, well-nourished male in no acute distress with a blood pressure of 105/50. He was slightly pale but otherwise the eyes, ears, nose and throat were not remarkable and the heart and lungs were clear to percussion and auscultation. The abdomen was negative. The prostate was described by the urologist as being hard with multiple calculi.

His laboratory studies at that time showed a red blood cell count of 3.1 million with 8.8 grams of hemoglobin and the white count of 6,150 with a normal differential showing 30% polys, 19% nonfilamented, 5% monocytes, 36% lymphocytes and 1% eosinophils. It was also noted that there were two myelocytes and seven metamyelocytes as well as two nucleated red cells per 100 white cells. X-ray films of the chest, lumbar spine and pelvis showed prostatic calculi and urinary retention. There was no evidence of metastatic involvement of the bones of the chest, spine or pelvis.

Following his admission at this date, it was realized that he had been taking Reserpine and because of the hesitancy of doing an operative procedure at this time, he was discharged to return in two weeks after stopping the medication. No change was noted on his physical examination when he returned and his blood studies still showed the anemia and young cells of both the red and white cell series in the peripheral blood. As he had some pyuria, he was prepared by being placed on antibiotics and given four units of whole blood. Ten days after admission a transuretheral resection of the prostate was done. Following this he had rather profuse bleeding which required returning him to the operating room for suprapubic cystoscopy and a packing of the prostatic fossa. He lost a great deal of blood during this and had to be transfused on repeated occasions.

He was seen in medical consultation by me at that time and was found not only to be bleeding excessively from the operative site but to have generalized ecchymoses as well as being semi-comatose. His plasma fibrinogen level was normal at 224 mg and the bleeding and clotting time normal. No evidence of a fibrinolysin was found. The platelet count had dropped to 50,000 and the BUN elevated to 156 mg. Repeated blood studies continued to show the nucleated red cells in the peripheral blood as well as myelocytes and metamyelocytes. In view of

the latter studies, a bone marrow examination was done which revealed many carcinoma cells in the aspirate. The acid phosphatase was found to be elevated to 11.5 units and the alkaline phosphatase to 50 units. Sections of the material removed at the transuretheral resection also showed carcinoma cells from the prostate.

This patient had a very stormy post-operative course but gradually with steroids, forced fluids, and 21 blood transfusions improved to a surprising degree. His jaundice cleared and his blood urea nitrogen fell so that on October 31st it was felt safe to do a bilateral orchiectomy, which he withstood without difficulty. Following this he was placed on stilbesterol and a month following this operation was sufficiently improved to be sent home.

He continued to do quite well until January of 1963 at which time he again noticed a marked increase in his weakness with weight loss and anemia and because of this was readmitted to the Roper Hospital. At that time he was once again anemic with a red count of 2.85 million and 8 grams of hemoglobin and a white count of 6,850 showing a normal differential. The acid phosphatase was elevated to 29.1 units and x-ray films showed many osteoblastic metastases in the bone. He had a steady downhill course and died approximately five months following his operation.

An autopsy was done the day of death which revealed very extensive metastatic carcinoma of the prostate involving the bone marrow.

Case 3.

Mr. L. R., a 56 year old colored male was first seen at the Medical College Hospital on September 16, 1963, when he was admitted to the Emergency Room in a semi-comatose state. His history was poor but apparently he had been in normal health until one week prior to admission, except for blindness secondary to cataracts and a questionable history of hypertension. At that time he began to complain of generalized pain and noticed rather frequent sweating. He vomited several times after this and continued to complain of fever but otherwise had no specific complaints. The morning he was first seen he was noted to be lethargic and unresponsive at times and there was some questionable history of opisthotonos. Because of these symptoms he was brought to the Emergency Room.

Physical examination at that time revealed a semi-comatose, colored, male with a blood pressure of 110/80, and a pulse of 110 which was regular. Respirations were 36. He was very pale and the skin was dry although turgor was good. Other than for the pallor, the eyes, ears, nose and throat were not remarkable. (The patient was edentulous but the throat was not injected) The lungs were clear to percussion and auscultation. The heart was not enlarged and had a regular sinus rhythm. The abdomen was negative. Rectal examination revealed the prostate to be slightly enlarged and hard but no nodules were noted. Other than for the clinical comatose state, there was no obvious neurological change and the reflexes were all normal.

The red count on admission was 2.5 million with 5.5 grams of hemoglobin and the white count 8,000 with a normal differential except for the presence of 24 nucleated red cells per 100 white cells. There was no record of a shift to the left in the myeloid series. Urinalysis showed a 1+ albuminuria. The stools were negative for blood. The BUN on admission was 50 mg but over the course of his hospitalization and treatment, it slowly fell to 26 mg. Numerous studies were done to rule in or out a hemolytic syndrome including a glutathione stability test (which showed him to be an intermediate reactor), acid hemolysis which was negative and a Coombs' test which was also negative. The serum iron was 147 micrograms, and the serum electrophoretic pattern revealed 40% hemoglobin S and 60% hemoglobin A. The foetal hemoglobin was .21. The serum hemoglobin level was 16.7 mg after transfusions. Lumbar puncture was completely negative. Uric acid was 12.6 and the total proteins within normal limits. The acid phosphatase was markedly elevated to a high of 41.3 King-Armstrong units, and the alkaline phosphatase went up on one occasion to 52 King-Armstrong units. The bilirubin was 1.5 mg and the calcium and phosphorus within normal limits. X-ray films of the chest, spine, pelvis, femur and skull showed no evidence of metastatic lesions.

Bone marrow aspiration was attempted on five occasions but yielded a dry tap each time. Consequently a bone marrow biopsy was done which was also non-revealing. A Vim Silverman needle biopsy of the prostate gave a histological diagnosis of carcinoma of the prostate.

He was treated with stilbesterol, orchiectomy and multiple blood transfusions with improvement and was discharged in much better shape on October 11, 1962.

He was followed in the clinic after this and was next admitted to the hospital on June 14, 1963 at which time he was once again extremely anemic with a markedly elevated alkaline phosphatase to 112 King-Armstrong units and an acid phosphatase to 21 King-Armstrong units. X-ray films of the chest at this time showed sclerotic changes in the thoracic vertebrae and possibly the ribs. Once again he was transfused and discharged to be followed as an outpatient.

On this latter admission no nucleated red cells were reported in his peripheral blood.

Discussion

In each of these cases presented, the correct diagnosis was not made initially despite the fact that the original blood studies were

abnormal, with nucleated red cells present in the peripheral blood. In the absence of any other cause for normoblastemia, such as severe hemorrhage, hemolysis or tissue hypoxia, this finding strongly suggested metastatic involvement of the bone marrow which was borne out in each case.

Carcinoma of the lung, breast and prostate have been most frequently reported as producing a myelophthisic anemia.[7] This was the case in that two of these three patients had metastic carcinoma of the prostate and the third had metastatic carcinoma of the lung. It is interesting that "dry taps" were obtained in two of the three patients on bone marrow aspirations, which is not unusual. The mechanism is thought to be due to the packing of the marrow's cavity with carcinoma cells. The patient with carcinoma of the lung had had known pulmonary asbestosis, which again might have given a clue to the correct diagnosis, since carcinoma of the lung has been reported in as high as 13 percent of patients with this form of pneumoconiosis.[8]

In conclusion, the presence of nucleated red cells in the peripheral blood is a finding necessitating careful consideration in view of the grave underlying disease which it so frequently accompanies.

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Innocent cardiovascular murmurs in the adult—W. F. Weaver (Bryan Memorial Hosp, Lincoln, Neb) and C. H. M. Walker. Circulation 29:702 (May) 1964.

A series of 100 young adults, who had innocent murmurs in childhood, were examined 16 years after their initial evaluation. No cardiac abnormalities were observed in the subjects, but a cardiac or vascular murmur was found in all. The maximal intensity of the murmur was heard in the third left intercostal space (LIS) in 46% of the subjects; in the first or second LIS in 31%; in the aortic projection or neck in 10%; and at the apex in 1%. The murmur was easily audible in the neck of 24% of the subjects. The murmurs were early to midsystolic in timing and 85% of these were vibratory in character. Their grade varied from 1/6 to 3/6 in intensity, changing appropriately with the subject's position, respiration, and exercise. The tape recorded sounds and murmurs on audio playback and oscilloscopic viewing correlated almost exactly with the stethoscopic findings. It is concluded that innocent systolic ejection murmurs are common in the adult, and the recent emphasis of the value of arterial auscultation is supported by the high incidence of murmurs heard in the neck. Since this tape recording technique accurately reflected the auscultatory findings, such systems would appear suitable for the use in heart disease screening programs.

Acute salicylate poisoning in adults—G. W. Beveridge et al (J. A. Owen, Royal Infirmary, Edinburgh, Scotland) Lancet 1:1406 (June 27) 1964.

The authors present their experience of the clinical and biochemical assessment of salicylate poisoning in adults with special reference to the indications for hemodialysis. In 208 patients, three of whom died, the initial treatment consisted of careful gastric lavage and a regimen of intravenous fluids sufficient to maintain an alkaline urine with a flow of over 500 ml per hour. Nine patients were considered, and four selected for hemodialysis. It is concluded that most patients respond to forced diuresis, but only by concurrent clinical and biochemical assessment can the patients requiring hemodialysis be selected. Deterioration in level of consciousness, hypotension, and serum salicylate values over 100 mg/100 ml are grave signs.

THROMBOTIC THROMBOCYTOPENIC PURPURA

A CASE REPORT

CHARLTON DE SAUSSURE, M. D.
Charleston, S. C.

Introduction

Although a rare disease, thrombotic thrombocytopenic purpura is being reported with increasing frequency and with a much more varied clinical course than was originally reported by Moschocowitz[1] and Baehr, *et al.*[2] Still the hemolytic anemia, thrombocytopenia and bizarre, often variable neurological signs are the cardinal clinical manifestations of this syndrome. In addition, fever, abdominal pain, nausea and vomiting are common and hepatosplenomegaly with lymphadenopathy may be found. The laboratory findings of proteinuria and azotemia further stress the protean manifestations of this disease.

Endothelial damage has been shown by Gore to be the most probable initial change rather than platelet thrombi. Moore and Schoenberg[4] have demonstrated the presence of an acid mucopolysaccharide of the chondroitin sulfate type involved in this endothelial change. The etiology nevertheless is unknown but the syndrome is most probably associated with the collagen diseases.

The following case report describes a typical example of this disease process except for a period of complete remission for fifteen months after the first symptoms were noted.

Mrs. J. B. H. was a 53 year old, white, Jewish female who was apparently in perfect health until approximately two months before her first admission to the Roper Hospital on March 17, 1960. At that time she first noticed the onset of generalized malaise and weakness but had no specific complaints. Two weeks before this first admission she noticed several bruises over her body and also some epistaxis with vigorous blowing of the nose. She also stated at that time she developed a pain in her head and her legs "felt like they were not with her." The only other complaint had been excessive thirst but she denied any history of jaundice, bloody or tarry stools, weight loss, etc.

On physical examination she appeared thin and chronically ill with marked pallor of the skin and mucous membranes. There were scattered ecchymotic lesions over the right wrist, right knee and a Rumpel-Leede test was markedly positive. The blood pressure was 114/72 mm Hg. The eyes were round, regular and equal and reacted to light and accommodation. The fundi were within normal limits. The remainder of the ears, nose and throat examination was not remarkable. The heart and lungs were clear to percussion and auscultation. There were scars of her previous bilateral simple mastectomies which had been done for chronic cystic mastitis. The liver was palpable two finger breadths below the right costal margin but the spleen was not felt. The remainder of the examination was within normal limits.

The red count on admission was 2.33 million with 7.5 grams of hemoglobin and the white count 14,800 with a normal differential except for the presence of one nucleated red cell per 100 white cells. The platelet count was reduced to 42,000 and the reticulocyte count elevated to 12.7%. The VPC was 25% which gave a macrocytic cell. Bone marrow examination showed a very cellular marrow with extreme erythroid hyperplasia at the normoblastic level. The urine was negative for bilirubin, porphyrins and urobilinogen. Total proteins, alkaline phosphatase, serum transaminase, three LE cell preparations, Coombs' test, serum bilirubin, cephalin flocculation, BUN, fasting blood sugar, stools and agglutination series were all negative or within normal limits. The serum iron was 195 micrograms/100 ml. A complete G.I. series was negative.

She rapidly became worse following her admission to the hospital and on the sixth hospital day she became febrile, disoriented, aphasic and completely unable to speak. Because of the obvious hemolytic component she was started on prednisolone in a dose of 40 mg every six hours and given 1500 ml of blood intravenously. This resulted in a marked rapid improvement in all of her symptoms and clinical manifestations including the anemia, purpura, aphasia, weakness, pallor and so forth. The predni-

Patient by courtesy of Dr. Ralph Coleman.

solone was gradually tapered off and she was discharged on a dose of five mg every six hours. After she had begun to improve, a red cell survival study was found to be normal. However, at the time she was clinically much improved. She was discharged on the seventeenth hospital day.

Following her discharge from the hospital she continued to do very well and was seen on several occasions as an out-patient and had perfectly normal complete blood studies. She continued to remain well until mid-July of 1961 when she began to notice the recurrence of weakness and occasional headaches. This was followed by the presence of wide-spread petechiae and rapidly developing anemia. She was readmitted to the hospital on August 8, 1961.

At that time she appeared well-developed and well-nourished and was extremely apprehensive although in no acute distress. There was once again marked pallor of the skin, mucous membranes and petechiae and ecchymoses primarily over the right thigh. On this occasion she had some axillary adenopathy. The heart and lungs were clear to percussion and auscultation. The liver was palpable again at the costal margin and the spleen tip was also palpable. There was again some speech aphasia at the time she was admitted to the hospital.

On admission her red count was 2.36 million with 7 grams of hemoglobin and the white count 15,900 showing a normal differential except for 34 nucleated red cells per 100 white cells. The volume of packed cells was 22% and the platelet count 30,000. The reticulocyte count was 3.9%. A bone marrow examination revealed an increased number of nucleated red cells with a M:E ratio of one to one; but otherwise was within normal limits with an adequate to excessive number of megakaryocytes. Urinalysis showed 4+ albuminuria and 25 to 35 red blood cells. The reticulocyte count on repeated determinations during her hospitalization went to 6.1% and 10.8% and the Coombs test remained negative. Again she was treated very intensively with steroids and blood transfusions but on this occasion had a progressively downhill course with stupor progressing to coma and finally respiratory arrest and died on her second hospital day, August 10, 1961.

Her post mortem examination revealed the chief changes in this individual to be related to the vascular system where there was wide-spread occlusion of capillaries and small arteries with granular eosinophilic, PAS and PTAH positive material. There was accompanying interstitial hemorrhage especially involving the myocardium with fatty degeneration of the myocardial fibers. Occlusion of the small arteries in the brain was noted and thought to be related to the cerebral symptom, but no parenchymal lesions of the brain were noted. The final pathological diagnosis was thrombotic thrombocytopenic purpura.

Discussion

The sudden onset of malaise, weakness and anemia followed by bleeding manifestations and later fever, disorientation, jaundice and speech aphasia is all typical of thrombotic thrombocytopenic purpura. In addition the laboratory findings of a hemolytic anemia with a negative Coombs test gave further support for this diagnosis. The patient was accordingly started on large doses of steroids and fresh blood transfusions and responded very dramatically.

Response to a large dose of cortisone has been reported by Burke[5] and Hill, *et al.*[6] The latter authors also advocated splenectomy following improvement with steroids which was not considered in this patient in view of her complete remission even after steroids had been discontinued. A similar remission has also been reported by Rubinstein[7] after exchange transfusions with fresh blood but it is impossible to attribute these responses to any specific factor.

Calahane and Horn[8] have reviewed 19 cases of prolonged survival collected from the literature but many of these presented the complete picture of the disease only in retrospect. Nevertheless, the great majority of the patients reported in the literature have died within a matter of weeks with a progressive downhill course as noted in this patient in her last hospitalization.

The laboratory findings have consistently revealed a negative Coombs test and negative LE cell preparations despite the rather typical picture of an acquired hemolytic anemia in the reported cases.[9, 10] In the present patient these two negative tests were the first indication of the correct diagnosis before her neurological changes appeared on her first admission. The radioactive chromium red cell survival was done after the patient had gone into a remission and is of no value in elucidating the pathogenesis of the hemolytic state.

It would appear that the remission in this patient was induced by the use of large doses of steroids plus blood transfusions. One wonders whether a more lasting type of remission

might have been obtained had splenectomy been performed in addition. Certainly no evidence of response to massive doses of steroids was noted on her terminal admission.

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Bed rest, sleep, and symptoms: A preliminary study of older persons—P. M. Tiller, Jr. (3600 Prytania St, New Orleans). Ann Intern Med 61:98 (July) 1964.

The best rest and sleep habits, and nonspecific symptoms, were studied in a group of alert and active older persons. Habitual daily sleep was found to vary from less than 4 hours to almost 12 hours. There was no evidence of a progressive decrease in sleep with advancing age. Discomfort from unexplained symptoms, particularly tension and fatigue, was moderate to severe in the majority of those persons who slept less than seven hours, while similar discomfort was mild or absent in the majority of those who slept eight hours or more. Persons who rested in bed during the day in addition to sleeping more than eight hours at night were relatively asymptomatic. Some of those who habitually slept less than seven hours were placed on a regimen of increased bed rest that included a day-time rest period. All of those who had not complained of insomnia experienced a more or less abrupt increase in sleep to eight hours or more at night. This was followed by a decrease in symptoms. Patients who complained of insomnia had a lesser increase in sleep and less symptomatic relief. This apparent relation of unexplained discomfort to habitual lack of sleep, and the decrease in symptoms following a regimen of increased sleep, should be evaluated with great caution. Additional studies would appear justified.

Arteriosclerotic aneurysm of the extracranial internal carotid artery treated by excision and primary re-anastomosis under controlled hypertension. Buxton, J. T., Jr., Stevenson, T. B., and Stallworth, J. M. Ann Surg 159: 222-226 (February, 1964.)

A case of arteriosclerotic aneurysm of the extracranial portion of the internal carotid artery which was successfully resected with end-to-end anastomosis is presented. This is thought to be the eleventh pathologically documented case in the literature. These aneurysms are rare, and progress to fatal complications if not treated.

Occlusion of the internal carotid carries a high morbidity and mortality. This justifies the use of all possible adjuncts. The use of intraluminal shunt, extraluminal shunt, or hypothermia carries some risk. Controlled hypertension would seem to offer the best protection. It can be used alone or with any of the above methods.

In this case a well-demonstrated external carotid communication is thought to have provided some extra margin of safety. The method used was to raise the patient's systolic blood pressure 50 mm above basal levels, using neosynepherine. A patent ductus clamp was applied distal to the aneurysm for a 10 minute test occlusion with monitoring by EEG. The aneurysm was resected and end-to-end anastomosis was performed with good flow being established after 24 minutes occlusion without EEG change noted.



President's Page

Sometimes, when we are asked to serve on a committee we are wont to say to ourselves: "Is this committee necessary?" We have so many meetings to attend, staff meetings, pathological conferences, section meetings, and many others, that the call seems too much. But when we analyze the reasons for such meetings we come to the realization that there is a function for each of them. In your hospitals the Record Committee is necessary to properly evaluate the attention that the doctor is giving his patients and to see that the records are complete for future reference by himself or some other doctor or the courts. The Tissue Committee exerts a strong influence on the surgeon who might have the tendency to use an over-active knife. The Credentials Committee is the first line of defense in protecting the standard of medical care.

Your Society committees make the operation of your local society more efficient and aid in straightening out problems in their incipiency. Your local society committees aid in developing and maintaining a proper doctor image to the public.

On the state level there are committees that are busy and there are committees that act on a stand-by basis. Problems arise during the year that are referred to the proper committee and that committee's investigation and opinion is valuable in determining the course that the state Association might take. We do find, however, that there have developed over the years committees on a state level that were created without thought or instruction as to their function. The various presidents utilize these committees as occasion directs but the original function is lost in vague minute description. It would be well that any motion presented to the House of Delegates having to do with the formation of a new committee or instruction to an old one, carry with it a clear description of the function to be performed and an expiration date.

There is one thing certain, that your service on a committee is a necessary service to the state Medical Association, and one that every doctor owes to the medical profession.

Frank C. Owens, M. D.

Editorials

Areawide Health Facilities Planning

In view of the concern shown by many interested physicians in certain proposals for areawide planning of hospital construction, and considering the suspicion which certain physicians have developed as to an eventual federal control which might result from such planning, the approaching national conference on areawide facilities planning, sponsored by the AMA, seems to be a valuable effort. The purpose of the meeting is to bring together the numerous groups and many disciplines interested in such planning and to explore the topic from many standpoints, including those of medicine, hospitals, government, insurance, consumer, and the planning agency.

This meeting will offer an opportunity for those who have their doubts about the wisdom of areawide planning to express them and for all parties concerned to put their cards on the table.

Arthritis

It is comforting to see than an agreement has been reached among the major organizations engaged in the support of research in the field of arthritis. Some years ago when the National Foundation abandoned to a considerable extent its original purpose of combating poliomyelitis, and decided to assume activities in several fields, including arthritis, it was felt by many that this parallel or duplicating effort was not desirable from the standpoint of the older Arthritis and Rheumatism Foundation. Now spokesmen for the American Rheumatism Association, the Arthritis and Rheumatism Foundation, and the National Foundation have said that efforts in the field will be combined under one organization, the Arthritis Foundation of America, which would be the only voluntary health agency in the field. The president of this new agency will be a former director of the medical department of the National Foundation. The new arrangement seems to be a desirable and logical step toward the common goal.

Superintendent of Education

On November 23rd, a referendum will be submitted to the people of South Carolina relative to the State Superintendent of Education. At the present time, the State Superintendent is elected by public vote. If the referendum is passed, the Superintendent will be appointed by the newly constituted State Board of Education. Since physicians are both tax payers and parents, they should be interested in this proposed amendment to the State Constitution.

Few of us would advocate that the State Health Officer be selected by popular approval and not by the Executive Committee of the State Board of Health. The State needs a Health Officer who is chosen because of his training and ability and not because of his public appeal. The same argument holds true with regard to the State Superintendent of Education.

We would urge that physicians discuss this matter with their colleagues and their patients and be prepared to cast their ballot on November 23rd.

J. P. P.

Dr. McCants to Be Honored

Dr. Charles Spencer McCants, Fairfield County's oldest practicing physician and a close associate of the Fairfield Memorial Hospital, is to have his portrait placed in that institution in honor of his long interest and service.

Previous to the building of the present hospital, Dr. McCants built and operated a small hospital of his own.

A native of Winnsboro, he began practice there after World War I, and has been active in local and state medical affairs ever since. In 1963-64 he was president of the Tri-State Medical Association. The portrait will be a fitting testimony to his place in medicine.

THE SOUTH CAROLINA MEDICAL ASSOCIATION MENTAL HEALTH COMMITTEE REACTION TO PRELIMINARY DRAFT OF GOVERNOR'S ADVISORY GROUP

We are pleased and gratified and encouraged by the interests and work of those serving on all the committees of the Governor's Advisory Group and all others seeking to improve the care and treatment of the mentally ill in our state. This major task requires the careful comprehensive concern of many people from all areas of community life. The many facets and complexities of the problems allow no simple solutions.

In the Preliminary Draft of the Governor's Advisory Group many facts are revealed, many principles have been expressed, and many proposals have been made. This committee believes that a number of these are correct, realistic and constructive. However, the committee quite strongly believes certain significant facts have been overlooked, that certain principles and proposals are dangerous and unacceptable.

Although the care and treatment of the severely disturbed, unmanageable psychiatric patient have in the past been traditionally predominantly the responsibility and work of the State, the vast majority of emotionally disturbed or mentally ill patients have been cared for in their homes or in general hospitals by private practitioners of medicine. The implication in the Preliminary Draft that the care and treatment of most of the emotionally ill is the concern of the State is incorrect and therefore disturbing and unacceptable to this Committee.

The terms, "emotionally disturbed" and "mentally ill" in the Preliminary Draft are used so broadly, varyingly, and loosely that many misconceptions arise, and are followed by unrealistic recommendations. Helping people suffering from delinquency, senility, job or school stress, or a major psychosis are problems completely differing in nature and magnitude. No physician, clinic, center, hospital, or institution can satisfactorily answer all such problems. More specific terms or concepts are necessary.

This Committee believes that the diagnosis, care and treatment of mental illness are inseparable from the diagnosis, care, and treatment of the physically ill and therefore requires a thorough knowledge of the basic sciences, including anatomy, physiology, pathology, psychology, pharmacology, etc., as well as clinical courses and supervised experience. Facilities, clinics, centers, or hospitals separating the diagnosis and treatment of the mentally ill from the physically ill have led, and will continue to lead, to incomplete, inadequate and incompetent relief. This committee strongly opposes separated, isolated diagnostic and treatment facilities for the mentally ill. We recommend incorporation of Mental Health Clinics and Centers into existing general hospitals.

Local education and responsibility need stimulation and enhancement in the care of the mentally ill. The tendency toward a massive State program decreases this essential local initiative and action.

We urge improved, realistic, nondiscriminatory insurance coverage for mental illness on a par with physical illness.

This committee believes careful consideration should be given toward a more realistic charge for State Hospital patients—such as has been done in clinics.

Success of care and treatment of the mentally and physically ill is directly and absolutely dependent on the skill and dedication of the physicians, nurses, and other assistants. This committee urges that the highest priority be given to the problem of manpower shortage. Most urgently needed are psychiatrists and nurses. Current programs of improved training for psychiatrists and non-psychiatric physicians should be greatly augmented at all levels. Great support and stimulation should be provided for nurses training in general as well as in psychiatric nursing.

This committee believes adequate staffing with skilled physicians of our present mental health facilities should be accomplished before additional physical structures are built.

Mental Health Committee
South Carolina Medical Association
James B. Galloway, M. D.
Chairman
Robert G. Thompson, M. D.
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Allan P. Bruner, M. D.
William T. Hendrix, M. D.
George G. Durst, M. D.



"I don't give a damn if it is Hippocrate's birthday — get me a doctor!"

A SERVICE TO PRIVATE PHYSICIANS AND THEIR OWN APPRAISAL OF IT.

R. W. Ball, M. D.

Chief, Venereal Disease Control Section
S. C. State Board of Health

It has long been an established fact that no public health endeavor can be accomplished without the support and cooperation of the private physician, as he is the nucleus around which all public health programs are developed. This cooperation must be reciprocal through services directed toward the physician in order to assist him in every way possible to serve his patients and his community better. This is particularly true in the field of venereal disease control, whereby the incidence of venereal infections can definitely be reduced by the joint efforts of public health and private medicine.

Venereal disease services to the private physicians by the South Carolina State Board of Health now include:

1. Darkfield microscopy (upon request) on private patients suspected of primary or secondary syphilis.

2. Keeping the private physician informed regarding the latest developments in venereal disease control.

3. Darkfield microscopy, venepuncture, laboratory or references pertaining to the diagnosis and treatment of venereal disease.

4. Confidential interview of private patients (but only with permission of physician concerned).

5. Epidemiologic follow-up on contacts obtained and reporting back to the physician the results of epidemiologic findings.

These services are rendered by highly qualified and trained young men (Program Representatives) on the staff of the Venereal Disease Control Section of the South Carolina State Board of Health. Their qualifications and training include:

1. A Bachelor's Degree from an accredited 4-year college or university.

2. Orientation in the medical aspects of the venereal diseases.

3. Darkfield Microscopy, venepuncture, laboratory procedures and interpretation of venereal disease laboratory tests and reports.

4. Studies in sexual behavior, including homosexuality and other sexual perversions.

5. A course of instruction in confidential interviewing of venereal disease patients to find the source and possible spread cases of their infection.

6. Investigative procedures as applied to contacts and other suspects.

At the present time the Venereal Disease Control Section of the South Carolina State Board of Health has on its staff 13 Program Representatives. Although backlogs in work loads occur from time to time, these men, being dedicated individuals, stand ever ready to make whatever contribution may be necessary to meet any emergency.

For some time, these Program Representatives (PR's) have personally visited physicians in private practice to explain the purpose of the Venereal Disease Program, to outline the services the Venereal Disease Control Section offers to the physicians, and to enlist their cooperation in the control of venereal disease in the community.

Physicians' Appraisal of Services

To obtain the physicians' evaluation of this phase of the Venereal Disease Program in South Carolina, a questionnaire was mailed on March 23, 1964, to 874 private physicians. Signatures were not requested. Consideration was given to type of practice because it is from the physicians in the categories shown below that the greatest number of VD Morbidity Reports are received.

Purpose of Study:

1. To evaluate the effectiveness of the Program.

2. To determine how well the Private Physician Visitation Program is being accepted by the private physicians themselves (their own viewpoint).

3. To pinpoint any weak links and to gather constructive suggestions from the private physicians as to program improvement.

DISCUSSION OF QUESTIONNAIRE REPLIES

Question 1—Type of Practice (Response)

	No. Q's Mailed	*No. Replies*	*% Response*
General Practitioners	710	342	48.3%
Dermatologists	14	11	78.2%
Proctologists	5	2	40.0%
Urologists	35	17	48.6%
Internists	110	64	58.2%
	874	436	49.9%

Of the 874 questionnaires mailed to private physicians in the categories shown above, it was most gratifying that practically 50% of the practitioners queried took time out from their practices to assist us in evaluating this phase of the Venereal Disease Control Program. Statistically this is considered an above-average response to this type of questionnaire. Further interest in this program is indicated by the large number of responses containing added comments.

Question 3—Visits By Appointment

Since 43% of the physicians stated that they preferred visits to be made by appointment, all Program Representatives (PR's) have now been directed to comply with this preference, unless the physicians concerned advise the PR's specifically to the contrary.

Questions 4-9—Ratings of Program Representatives

In some instances, the physician indicated that the question did not apply to him, for reasons discussed later. Of these physicians to whom the questions did apply, however, more than 98% approved (rated excellent, good, or fair) every aspect of the PR's and their services.

Professional Manner of PR's

This item was rated good to excellent by 99.2% of physicians replying. This was gratifying but also understandable in view of one of the major objectives in our training program, which is deportment with professional dignity in affiliation with a professional organization.

Question 5—Darkfield Services:

Over 93% of the physicians rated the darkfield services from good to excellent. A large number of the doctors explained on the questionnaire that this question did not apply to them since they either performed their own darkfields or that they seldom, if ever, saw infectious lesions of syphilis (See also Q. 10), or that they had had no occasion to request this service.

It should be added, at this point, that the PR's are qualified and ready at any time to perform darkfield examinations on any private patient upon request of the attending physician. These men may be reached through a telephone call to the local health department, from whence the call may be relayed to the appropriate program representative, wherever he may be.

Question 6—Epidemiology

Another point which should be emphasized is the *CONFIDENTIALITY of epidemiologic procedures.* All venereal disease information received from a patient, his contacts, the attending physician, or anyone else, is kept in strictest confidence, filed under lock and key, and may not be revealed to anyone other than essential legally constituted authorities. To violate this confidence would result in immediate dismissal, liability to prosecution for misdemeanor, and possibility of lawsuit by those concerned.

Question 7—"The Usefulness of the Material He Left Me Was . . ."

Material mentioned in Q. 7 refers to pictorial aids, current literature, and other information on the venereal diseases, and any other hand-carried items which may be available and useful to the busy practitioner. It is our endeavor to keep private physicians supplied with such material whenever and as soon as available. Ninety-eight percent of the physicians found this material useful to some degree.

Question 9

With reference to Q. 9, the confidence in (and support of) our epidemiologic services to physicians as expressed by 98% of those replying, is profoundly appreciated, and every effort will be exerted to maintain the highest standards of professional services.

Darkfields and Interviews

Do you request (or grant permission for) the VD Program Representative to:

	Yes	*Sometimes*	*Never*
10. Do a darkfield examination on a suspicious lesion or rash?	76.4%	18.5%	5.1%
	94.9%		
11. Interview in confidence your patients with early infectious syphilis and follow-up on their contacts?	80.5%	17.5%	2.0%
	98.0%		

Question 10—"Do You Request (or Grant Permission for) the VD Program Representative to Do a Darkfield Examination on a Suspicious Lesion or Rash?"

As indicated by replies to Q. 10, approximately 95% of the responding physicians are either utilizing or are in favor of darkfield services rendered. This is well, because identification of *T. pallidum* in a suspicious lesion through darkfield examination facilitates an immediate diagnosis of early infectious syphilis, which in turn calls for immediate treatment, immediate interview, and immediate epidemiologic follow-up of contacts. Its importance and the physicians' approval of this service is substantiated by the fact that during the calendar year 1963, physicians in South Carolina requested that 364 such examinations be performed by PR's and in 120 of these examinations treponemas were demonstrated, resulting in 120 confidential interviews and epidemiologic investigations which otherwise could well have been missed. More and more physicians are requesting darkfield services as evidenced by the fact that during the first four months of 1964 (January, February, March, and April), 169 darkfields were done, of which 88 were positive. At this rate, we can expect to perform over 500 darkfield examinations for physicians throughout the state during this calendar year.

Question 11—"Do You Request (or Grant Permission for) the VD Program Representative to Interview in Confidence Your Patients With Early Infectious Syphilis and Follow Up on Their Contacts."

With reference to the confidential *interview* of patients with early infectious syphilis (Q. 11) this is the first and most important step in the epidemiology of syphilis. Each case of primary or secondary syphilis represents the beginning of an epidemic and, unless the patient is interviewed and the contacts, suspects, and associates are followed up epidemiologically, the spread of the disease is unlimited, geographically or otherwise. Each time a physician grants permission for interview of his patient, with appropriate follow-up, he is not only living up to his professional responsibility in the control of an infectious disease but is rendering a tremendous ser-

vice to his community and his state as well. The recent epidemic of early syphilis in and around Gaffney, South Carolina, came to light when a private physician reported a case of primary syphilis to the health department and granted permission for interview and follow-up. This single act of cooperation plus comparable cooperation of the entire medical group in that area resulted in bringing under early control an epidemic which otherwise could have reached tremendous proportions. It represents a classic example of what can be accomplished when private medicine and public health join hands in the attainment of a common objective.

Last year, private physicians requested that our Program Representatives interview 273 patients that had been diagnosed with early infectious syphilis. I point this out to emphasize the fact that interviews are being done on a large number of private physician patients and being done in a most discreet and confidential manner. I urge each physician to call upon our epidemiologists for their aid in locating the source and all possible spread cases for every diagnosed case of infectious syphilis.

Question 12—Reports on Epidemiologic Follow-Up.

12. Does the VD Program Representative report back to you the results of his epidemiologic follow-up on your patient's contacts?

YES	NO
75.1%	24.9%

It is equally important that the referring physician be apprised of the results of epidemiology on his patient and for that reason all Program Representatives have been instructed that this is now a "must." Such reports, however, do not include the identity of contacts or others in the chain of infection as that would be a violation of confidence, but certainly the physician has every right to know the magnitude of the epidemic of which his patient has inadvertently become a part.

Question 13

13. Do you object to the VD Program Representatives' Visits?

YES	NO
1.4%	98.6%

If "Yes," please state reasons:

It is of great significance that visits by Program Representatives were shown to be acceptable to almost 99% of the physicians who answered this question. Only six physicians indicated that they objected to the Program Representatives' visits. The reasons given were mostly personal. The affirmative response to this question encourages us to keep in more or less constant touch with the medical profession on an individual basis and keep them ever mindful of the services which the State Board of Health has to offer them at all times.

Question 14—Suggestions for Program Improvement

About 30 physicians made suggestions of one kind or another and in several instances the same recommendations were made by two or more individuals. Several important areas needing improvement were pointed out. These included:

a. Delay in Program Representative reaching patient when darkfield examination is requested.

Comment: If there were Program Representatives in every county this would be no problem. Part of the difficulty is in making telephone contact when the Program Representative is somewhere in the field or perhaps two or three counties distant. Under such circumstances we would suggest that the physician call the local health department. If the Program Representative cannot be located, then the physician may call the Venereal Disease Control Section of the State Board of Health in Columbia (collect) and a Program Representative from another area will usually be dispatched without delay.

b. A more complete and uniform system of reporting back to the physician the results of epidemiological investigation on each patient referred.

Comment: All Program Representatives have now been instructed to report back to the referring physician on each case as soon as possible after completion of epidemiologic investigation.

c. Several physicians recommended that more intensive efforts be directed toward the control of gonorrhea.

Comment: We agree that this is also a need and with sufficient personnel a great deal could perhaps be accomplished in this area. It is hoped that if and when early infectious syphilis is brought under adequate control that an effective program may be directed toward the control of gonorrhea.

d. The need for more venereal disease education in the schools, for the public, and even among the medical profession, was stressed by several at the end of the questionnaire. One physician recommended that VD representatives appear on local medical society programs.

Comment: This office would of course be pleased to accept such invitations for the representative concerned at any time. As far as the schools are concerned, a tremendous amount of work has been and is still being done through the County Health Departments. With reference to VD publicity in general, the VD Control Section has been responsible for a number of radio programs, TV appearances, newspaper articles, lectures both lay and professional and articles in local, state, and national medical journals. These activities will be continued to the extent possible.

Summary

In order to obtain individual evaluations by private physicians as to services rendered them by the Venereal Disease Control Section of the South Carolina State Board of Health, a questionnaire was mailed to 874 physicians in certain high reporting categories. Approximately 50% responded and the vast majority of these were fully cognizant of the services rendered and were heartily in favor of them.

SURGERY IN RURAL SOUTH CAROLINA

W. G. Armstrong, M. D., F. A. C. S. and
James W. Forrester, M. D., F. A. C. S.
Georgetown, S. C.

There is undoubtedly a fundamental change taking place in the distribution of General Surgeons. There is reason to suspect that relative saturation of the metropolitan areas is causing an increasing number of young surgeons to heed the plea of their elders to become more rural in outlook. For one spawned in sophisticated surroundings, the course of this trend remains uncharted. Perhaps it would be appropriate to examine some of the things that have happened in South Carolina in the interval 1953 to 1961 for which data is conveniently available.

The number of South Carolina surgeons holding American Board of Surgery certificates in 1953 was 37; in 1961, 82. The per cent of these surgeons born in the state has increased from 57 to 65. Those receiving part or all of their training in the state have increased from 32 to 40 per cent.

In this state, the population of Board Surgeons is increasing in proportion much faster than is the general population. The resources of the state are becoming increasingly effective in providing for its surgical needs. Since 1953, twenty-two of the 45 general surgeons have settled outside the major population centers of Charleston, Columbia, Greenville, Spartanburg, and Anderson. Twenty-five communities were being served by these certified surgeons in 1961. At least nine smaller communities acquired such men for the first time. The fate of those who elect rural practice is unknown.

Georgetown, with a population of approximately 15,000, is the county seat in a service area of an estimated 40,000 people. There is a one-hundred bed Hill-Burton community hospital with two well-equipped operating rooms, a recovery room, and two competent nurse anesthetists skilled in the use of the endotracheal tube. Hospital by-laws require that only certified surgeons may perform major procedures. The medical community consists of ten general practitioners, a radiologist, a pediatrician, an internist, and an obstetrician-gynecologist, either Board eligible or certified. There are two general surgeons, both university trained, the authors of this paper. The senior author has been in practice over thirteen years, the junior five. The two are associates.

The accompanying table will give an indication of the types of surgical problems encountered. The purpose is not to stress numbers of various specific kinds of cases. The spectrum of problems shared by men of slightly varying interest is important. Not apparent perhaps, is the need for skill in the techniques of endoscopy and regional anesthesia. Increasing violence on the highways is a constant contribution to our material. The patients frequently show multiple injury and cannot in good conscience be moved any significant distance. Detailed knowledge of the surgical sub-specialties is requisite for proper care. Not infrequently rural surgeons must face problems which would put any university center on its mettle.

There was a school of thought that the general surgeon in smaller communities need not be as highly trained as the standard residency program would render him. In fact, an abbreviated program has been mentioned as a possible solution to the once short supply of rural surgeons. Such a proposal would not seem to be valid. Qualified professionals are dispersing into the suburban and stable rural areas. In both an elective and emergency sense it can be

REPRESENTATIVE OPERATIONS

Procedure	1959	1962
Head and Neck		
Thyroidectomy	13	19
Other	6	6
Chest		
Radical mastectomy	3	1
Other (Endoscopy, tube thoracotomy, etc.)	8	9
Abdomen		
Appendectomy	58	42
Cholecystectomy	18	29
Common duct explorations	9	3
Herniorrhaphy	108	72
Colon resections	13	5
Small bowel resections	9	8
Sub-total gastrectomy	5	11
Others	25	17
Pelvis		
Hysterectomy	14	31
Adnexal procedures	24	24
Other (outlet repairs, cesarian section, etc.)	11	7
Urinary Tract		
Nephrectomy	1	6
Prostatectomy	2	1
Other (cystoscopy, etc.)	28	44
Extremities		
Fractures	29	37
Tendon Repair	5	4
Varicose veins	17	13
Other (amputations, skin grafts, nerve and vessel repairs, etc.)	27	15

shown that citizens are desirous of remaining in their home communities if proper general surgical care and hospital care are available. There is a certain decentralization trend in clinical medicine.

There is another aspect of this broad subject which will no doubt attract increasing attention. What of the adequacy of the university centers which produce the young men and women who will be responsible for these sick people in rural communities? This has become a matter of high importance. The public is awaiting a solution of its medical problems and judges critically the medical and surgical care it is receiving. There is restlessness afoot and our errors might well meet with harsh judgment.

The essayists appreciate the delicate nature of the subject, but there seem to be forces at work upon our university centers which may have an adverse effect on adequate clinical training. These forces, oversimplified, are a part of the problem of financing medical schools. Nearly all of our nation's medical schools depend heavily on outside sources of funds for which there is considerable competition. Usually the contest is in the field of "research," an area of unquestioned importance. It becomes incumbent upon a medical school to attract and stimulate active workers who can bring honor to the institution in the field of research. The quest for candidates becomes a "full-time" job. The result can become a relatively single-minded department of surgery and an intolerable discrepancy between the broad surgical experience needed to serve the public and the more limited interest of a department concerned primarily with research.

The developing general surgeon can be crowded from positions of experience and responsibility in the surgical sub-specialties by the pressures of ever-increasing fine specialization. The training base must not be allowed to contract at a time when it should be enriched to prepare the trainee for skillful management of the wide variety of existing problems.

If the surgical clinician continues to lose importance, there will surely follow a wedge similar to that placed between the generalist and the specialist in the last generation. American medicine would certainly not be the winner.

News

The State Superintendent of Education

By overwhelming votes in the House and Senate the South Carolina Legislature has authorized a referendum in the general election on November 3rd to determine if the people favor appointment of the State Superintendent of Education. We feel it imperative that the newly constituted State Board of Education be given the authority to appoint the Superintendent for the following reasons:

1. The new State Board of Education has the responsibility for developing educational policies and it can best implement these policies only through an administrator directly responsible to it.

The 15 members of this Board, who were elected to represent the people by the members of the Legislature in their respective Judicial Circuits favor the proposed referendum so that they can carry out effectively the wishes of the Legislature, the desires of the people for quality education, and the heavy responsibilities assigned to the Board by the General Assembly.

2. Many well qualified men would accept appointment who would not consider running for the position.

3. An appointive procedure would be less likely to result in lifetime tenure as the State Board of Education could best evaluate leadership of the State Superintendent.

4. If the State's authority in the field of education is to be protected, a high degree of coordination and cooperation between the State Board of Education and the State Superintendent is imperative.

5. Since 1951 there have been 5 separate studies of the State Department of Education and all 5 of them have recommended appointment of the State Superintendent of Education.

6. Many state groups vitally interested in quality education endorse appointment; to name a few, the South Carolina Association of School Boards; South Carolina Education Association; South Carolina Congress of Parents and Teachers; South Carolina State Chamber of Commerce; and the Joint Legislative Committee to Study Public Education in South Carolina.

We earnestly urge that you vote "in favor of the amendment" as enacted by the 1964 General Assembly.

South Carolina Association of School Boards.

First National Conference on Areawide Health Facilities Planning

The First National Conference on Areawide Health Facilities Planning will be held in Bal Harbour, Fla., Nov. 28-29, the American Medical Association has announced.

Sponsored by AMA's Council on Medical Service, the day and one-half meeting will be at the Americana Hotel and will immediately precede AMA's 18th clinical convention.

According to Willard A. Wright, M. D., Williston, N. D., Chairman of the Conference, the meeting is

being held to gain insight and understanding into the growing need for health facilities planning.

MEDICAL ETV

November 5 and 6, 1964

ACUTE MYOCARDIAL INFARCTION

Guests—

Dr. George C. Griffith, Prof. of Medicine
University of Southern California

Dr. A. Calhoun Witham, Assoc. Prof. of Medicine
University of Georgia Medical School

December 3 and 4, 1964

TREATMENT OF CONGESTIVE HEART FAILURE

Guest—

Dr. George Burch, Prof. of Medicine
Tulane University Medical School

In addition to these South Carolina TV productions, programs from other centers will be shown on the *third Thursday* of each month, at 8:00 P. M. Scheduled this fall are:

October 15, 1964

Cancer of the Lung (N. Y. Acad. of Medicine)

Drs. John R. Pool, L. G. Koss, Eugene E. Cliffton

November 19, 1964

Treatment of Peptic Ulcer (Univ. of Utah)

Drs. Kenneth B. Castledon, Edwin Englert

NOTE—*All Thursday* programs are carried on both the closed-circuit ETV Network *and* Channel 7 (Charleston), Channel 29 (Greenville). Friday showings are on closed-circuit into the schools and hospitals only.

Ohio Doctor to Practice in Greenville

Dr. John A. Driesbach, a native of Ohio, has become associated with Dr. Robert C. Grier, Jr. in the practice of orthopedic surgery.

Dr. Driesbach was graduated from Findlay College, Findlay Ohio, and received his M. D. degree from Ohio State University College of Medicine in 1946.

He has just completed his last year of orthopedic training at Riverside Methodist Hospital in Columbus, Ohio.

Doctors to Practice in Edgefield

Drs. W. H. Turner and B. E. Nicholson have returned to their hometown of Edgefield to practice medicine. Both doctors finished the Medical College of South Carolina in 1961.

Dr. Thomas Named 'Man Of The Year'

Dr. O. L. Thomas was named Ninety Six's Man of the Year.

Dr. Thomas became the 14th man to receive the annual award presented by the Ninety Six Lions Club.

The physician came to Ninety Six to practice medicine in 1950 after practicing a short while at Joanna and after finishing his internship at Greenwood Hospital. He is a graduate of the Medical College of South Carolina at Charleston.

Pee Dee Program To Study Football Injuries

Florence, Darlington and Timmonsville high school football coaches and principals have completed plans to begin a pilot study of football injuries in this area.

Dr. W. M. Hart of Florence conducted the meeting. Six schools were represented.

Dr. Howard to Practice in Greenville

Dr. P. K. Howard, 1954 graduate of the Medical College of South Carolina, has joined Drs. John S. McCutcheon, Jack M. Vander Wood, James M. Lane and James S. Barr in the practice of anesthesiology.

Dr. Howard did his undergraduate work at Wofford College and received a degree from Furman University. He served his internship at Greenville General Hospital.

He was a general practitioner at Woodruff for seven years prior to receiving anesthesiology training at Duke University in 1962.

Dr. Buxton Opens Office

George E. P. Buxton, M. D. announces the opening of his office for the practice of anesthesiology at 1124 Kensington Drive, Charleston.

Dr. Riddle to Greenville

Dr. C. D. Riddle, Jr., a native of Greenville, has become associated with Drs. Frank Stelling and Leslie Meyer in the practice of orthopedic surgery.

Dr. Riddle was graduated from Furman University in 1953 and received his M. D. degree from the Medical College of South Carolina in 1957.

He served his internship and residency in orthopedic surgery at the Medical College of South Carolina and for the past two years has been on active duty with the U. S. Navy at the United States Naval Academy.

American Medical Association To Stage Sixth National Conference On The Medical Aspects Of Sports

The Sixth National Conference on the Medical Aspects of Sports sponsored by the American Medical Association, under the auspices of the AMA Committee on the Medical Aspects of Sports, will be held in Miami Beach, Florida, at the Deauville Hotel on November 29, 1964. The Conference will be held in conjunction with the Clinical Convention of the American Medical Association, November 29-December 2, 1964.

Those interested in receiving announcements concerning the Conference should address the Secretary, Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Florida State Pediatric Meeting

November 12-13-14, 1964 at the Colony Beach Resort, Sarasota, Florida.

Evaluation Guide

The sixth and seventh guides in the series of "Guides to the Evaluation of Permanent Impairment" developed by the Committee on Rating of Mental and Physical Impairment are now available:

"Guides to the Evaluation of Permanent Impairment—The Digestive System"
and
"Guides to the Evaluation of Permanent Impairment—The Peripheral Spinal Nerves"

These guides, like all the others in the series, have been designed primarily for use by physicians. The guides are, however, of interest and use to all concerned with the medical, administrative, or judicial aspects of programs for the disabled. The previously published guides in the series deal with the extremities and back; the visual system; the cardiovascular system; ear, nose, throat, and related structures; and the central nervous system.

A limited number of copies of these guides may be obtained, without charge, upon written request to the Committee on Rating of Mental and Physical Impairment, 535 North Dearborn Street, Chicago, Illinois 60610.

State Board Of Medical Examiners Of South Carolina

The State Board of Medical Examiners of South Carolina held written examinations at the Columbia Hotel, Columbia, on June 16, 17, 1964. Seventy-four physicians passed the written examinations and have been licensed. Seventy-one of the successful candidates are recent graduates of the Medical College of South Carolina.

The successful candidates are as follows: Drs. John M. Barnard, Cherry Grove Beach; William N. Bennett, Bennettsville; Billy R. Blackwell, Hartsville; Asbury C. Bozard, Jr., Manning; Dee C. Breeden, Bennettsville; Juan A. Brown, Greenville; Edmond W. Camp, III, Anderson; Thomas B. Carroll, III, Hardeeville; James B. Causey, Furman; James W. Childs, Liberty; Maxwell E. Cline, Spartanburg; John W. Cochran, York; Alton B. Currie, Jr., Great Falls; James F. Dusenberry, Jr., Laurens; Floyd E. Ellison, Jr., Easley; Ben N. Estes, Clemson; Elliott R. Finger, Marion; Clyde M. Gaffney, III, Greenville; John Gatgounis, Charleston; Franklin L. Geiger, Jr., Columbia.

Also, Drs. James G. Gibbs, Jr., Charleston; Hal G. Gillespie, Norris; Edward F. Good, Charleston; Jimmy L. Gowan, Buffalo; Harold W. Gowdy, Jr., Lake City; Louis N. Gruber, Columbia; Phillip J. Haggerty, Gaffney; Torrence G. Hanner, Jr., Columbia; James M. Hayes, Jr., Andrews; James C. Hiott, St. Matthews; Alton T. Holland, Cassatt; Jordon M. Holloway, Ware Shoals; Axalla J. Hoole, IV, Florence; Thomas E. House, Greenville; Walter L. Hudson, Jr., Greenville; Robert B. Hunt, Columbia; Rodney K. Hutson, Orangeburg; George M. Jervey, Charleston; Douglas J. Jones, Jr., Walterboro; Lewis M. Jones, Sumter.

Also, Drs. Alexander L. Kolibac, Columbia; Arthur M. LaBruce, Jr., Georgetown; Francis M. Lemmon, Jr., Spartanburg; Richard A. Mann, Cayce; Edward C. Mattison, Florence; Hugh C. McCord, Jr., Hodges; Ben M. Meares, Columbia; Joe B. Meek, Spartanburg; James C. Owens, Columbia; Charles E. Preacher, Kingstree; Henry M. Ramseur, Greenville; Herbert V. Rast, Jr., Swansea; Stanmore E. Reed, Columbia; Donald W. Rhame, Clinton; Frederick Richards, II, Charleston; Gerald M. Rittenberg, Charleston; William G. Roche, Greenwood; Martin K. Rosefield, Jr., Sumter; John R. Satterfield, Jr., Winnsboro; Robert M. Scoville, Barnwell.

Also, Drs. George L. Sheppard, Jr., West Columbia; Dyrc F. Sibrans, Clemson; Palmira S. Snape, Easley; James H. Stafford, Jr., Florence; James K. Stokes, Newberry; Ronald K. Terrell, Lyman; William B. Thomason, York; William M. Turner, Mount Pleasant; William N. Walton, Charleston; Henry A. Wells, Jr., Rock Hill; Ackerman C. Williams, Jr., Branchville; Joseph T. Williams, Jr., Rock Hill; Hyrum D. Woods, Charleston Heights; William M. Woodward, Lugoff.

The next written examinations of the State Board of Medical Examiners of South Carolina are scheduled for November 10, 11, 1964.

New Spartanburg Surgeons

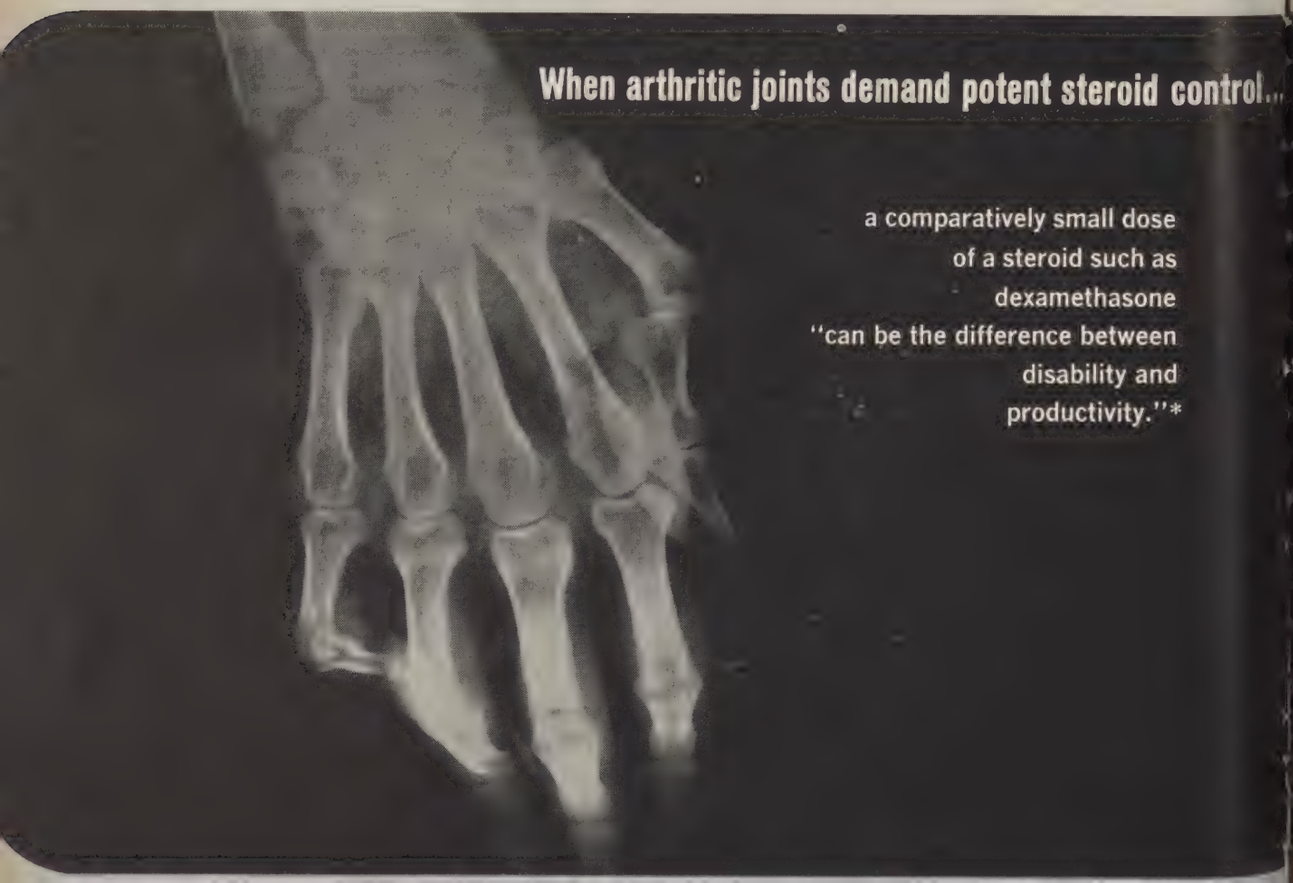
G. B. Hodge, M. D. announces the association of Kenneth T. Williams, M. D. and William C. Elston, M. D. in the practice of general, thoracic, and cardiovascular surgery at Hodge Clinic, 3 Catawba Street, Spartanburg.

Dr. Kenneth T. Williams graduated from Duke University School of Medicine, interned at Yale. He served two years in the Paratroopers Medical Corps. He completed his general surgical residency at the University of Georgia Medical Center under Dr. William H. Moretz and his thoracic surgical residency under Dr. Robert E. Ellison.

Dr. William C. Elston attended Indiana University and graduated from St. Louis University School of Medicine. He received his training at the University of Mississippi Medical Center under Dr. James Hardy in general and thoracic surgery.

New Bulletin

The Journal has received Number 1, Volume 1 (August, 1964) of the "Southern Branch Bulletin, official publication of the Southern Branch, APHA. This new publication is a news organ for the Association. Dr. Malcolm Dantzler of Charleston is a member of the editorial board.



and you demand maximum safety and low cost for your patient

DexamethBRAND OF Dexamethasone

Tablets 0.75 mg. and 0.5 mg.

☐ DEXAMETH possesses greater anti-inflammatory potency per milligram than most steroids ☐ with less tendency to produce undesired effects ☐ available at substantially reduced cost to patient

PRECAUTIONS: At therapeutic dose levels, DEXAMETH (dexamethasone) may have less tendency to cause sodium or water retention, potassium excretion, disturbance in glucose metabolism or hypertension than some of the older steroids. With these exceptions, however, the drug may give rise to the metabolic and hormonal side effects characteristic of corticosteroids. It should, therefore, be used with great caution in the presence of tuberculosis and other infections, osteoporosis, peptic ulcer, fresh intestinal anastomoses, diverticulitis, thrombophlebitis, herpes simplex, psychotic tendency, pregnancy and in persons exposed to chickenpox, measles or scarlet fever.

CONTRAINDICATIONS: Ocular herpes simplex, arthritis complicated by psoriasis, tuberculosis of the eye and skin, fungal keratitis, local pyogenic infection.

Before prescribing, consult product brochure.

DOSAGE: In rheumatoid arthritis, the initial daily dosage ranges from 1.5 to 3.0 mg. The dosage is then decreased gradually to the minimum that will maintain sufficient relief; this may be as little as 0.75 mg. per day. After extended therapy, it is especially important that the drug be withdrawn gradually to allow recovery of normal adrenal function.

* Rothermich, N. O.: Postgrad. Med. 35:117, 1964.

U.S. VITAMIN & PHARMACEUTICAL CORPORATION, 800 Second Ave., N. Y., N. Y. 10017

HEALTH MOBILIZATION TRAINING COURSE

A State Health Mobilization Training Course sponsored by the South Carolina State Board of Health, South Carolina Civil Defense Agency, co-sponsored by the Veterans Administration Hospital of Columbia, South Carolina and in cooperation with the U. S. Department of Health, Education and Welfare, Public Health Service, Region IV, Health Mobilization Services and Communicable Disease Center Training Branch, Health Mobilization Training Section, Atlanta, Georgia, is scheduled to be held at the Veterans Administration Hospital, Columbia, South Carolina, *October 27 and 28, 1964.*

PURPOSE OF THE COURSE

This Health Mobilization Training Course is designed to provide a better understanding and to acquaint physicians, dentists, veterinarians, nurses, pharmacists and other members of the health team about their primary and responsible roles in emergency health preparedness.

Physicians have a vital role and responsibility within the State and their respective community emergency health organizations. In disaster situations, the health service is the instrument through which are applied all available community health resources — manpower, supplies and facilities. The medical profession has the primary responsibility in the development and preparation of emergency health service plans and following a disaster must take the leadership in all phases of emergency health operations.

Hopefully, we anticipate that through the knowledge and understanding gained by attendance at this course, members of the health team will return to their communities better prepared to participate actively in all phases of the important County Health Mobilization Program and establish or strengthen leadership in emergency health service plans, programs and activities.

REMEMBER — TOTAL EMERGENCY PREPAREDNESS IS BASED ON INDIVIDUAL AND GROUP SELF-SUFFICIENCY—HEALTH MOBILIZATION TRAINING AND PROGRAMS AND IN ACHIEVING THESE REQUIREMENTS.

1964—An Epidemic Year for Rubella (German Measles)

The latest figures released by the National Disease and Therapeutic Index (N. D. T. I.), which is a nationwide survey of private medical practice, shows visits for German measles reached epidemic proportions in the first six months of 1964. N. D. T. I., which measures the number of patient-physician contacts involving various diagnoses, estimated physicians received over 1.8 million visits for rubella (German measles) since January of this year. This represents almost a 500% increase over the same period last year.

Historically, the first half of the year accounts for the largest share of rubella visits. This can be clearly seen in the following table which shows a breakdown of visits for the years 1960 through June, 1964.

U. S. Patient Visits for Rubella (German Measles) by Calendar Quarter

	1960	1961	1962	1963	1964
Jan.-Mar.	65	155	145	105	645
Apr.-June	215	220	215	220	1210
Jul.-Sept.	135	80	75	165	
Oct.-Dec.	80	65	100	100	
Annual Total	495	520	535	590	1855 (to date)

A regional break of N. D. T. I. information shows that 1964 rubella visits were higher than average in the East, particularly in the New England and Middle Atlantic states. The Eastern half of the country usually accounts for 25% of all visits to private practitioners; rubella visits showed 36% in this region.

N. D. T. I. further reported that an age breakdown on German measle visits showed that the epidemic was confined almost entirely to children and teen-agers with only about 1/5 of the visits being accounted for by adults. The sex breakdown for rubella was about average with females accounting for approximately 60% of the visits to private physicians.

Dr. Compton Joins Staff at Scurry Clinic

Dr. John DeVore Compton, Jr. has joined the staff of Scurry Clinic, Greenwood, in the practice of general medicine.

A native of Greenwood, he graduated from the University of South Carolina School of Pharmacy and the Medical College of South Carolina. He is a member of Alpha Omega Alpha, medical fraternity.

After a year as intern in Columbia Hospital, he served two years in the Air Force, stationed in San Antonio, Texas.

Speech Training

The Smith Kline & French Laboratories has established brief courses in the technique of public speaking with a view toward promoting increased lay understanding of the contributions of the health team and the pharmaceutical industry. Training seminars are two days in length, although one day instruction is also obtainable. A professional speech instructor conducts the course, which has been utilized by a number of organizations including the AMA and medical societies of several states.

Blue Cross-Blue Shield Plans Building

A new home office building at the intersection of Interstate 20 and Alpine Road, north of Columbia, is planned for the near future. The concrete structure will offer 72,000 square feet of working and storage space. This construction does not involve any additional cost to subscribers and should provide savings in operating expenses.

Southeastern Regional Meeting, American College of Physicians

The Annual Southeastern Regional Meeting of the American College of Physicians will be held at the Fort Sumter Hotel, Charleston, South Carolina, on Friday and Saturday, October 16th and 17th, 1964. All Fellows and Associates of the College are urged to attend, and non-members and students interested in Internal Medicine are especially invited.

The College will be represented by Dr. Thomas M. Durant, F.A.C.P., President.

The Scientific Sessions will be held at the Fort Sumter Hotel in the Charleston Room beginning at 8:45 a. m. Friday and Saturday.

Dr. Nickles To Open Practice

Dr. M. B. Nickles, Jr., has opened an office at 1627 South Fifth Street, Hartsville, for the practice of internal medicine and general medical practice, excluding obstetrics.

A native of Laurens, Dr. Nickles attended Clemson College and received his B. S. degree in 1955. He graduated from the Medical College of South Carolina in 1959. Dr. Nickles served one year rotating internship at Greenville General Hospital, Greenville.

Following his internship, Dr. Nickles was associated with Dr. James B. Berry, Jr. in the general practice of medicine in Marion. In January, 1961, he entered the U. S. Army and attended the Army Medical Service School at Ft. Sam Houston, Texas, later being assigned to Noble Army Hospital at Ft. McClellan, Alabama. While at Ft. McClellan, Dr. Nickles served as chief of out-patient clinics of Noble Army Hospital and was also assigned to the pediatric service for one year, furthering his training and experience in infant and child care.

After his discharge from the Army, Dr. Nickles returned to the Medical College of South Carolina, spending one year's residency in internal medicine. Then, he received six months training limited to diseases of the heart and cardiovascular system.

Dr. Morrison At Georgetown

Dr. Richard L. Morrison, III has joined the staff of the Miller, Tiller and Quinn Medical Clinic in Georgetown, where he will practice general medicine.

Dr. Morrison was educated in the schools of Georgetown and was graduated from the Citadel and from the Medical College of South Carolina in 1961. He completed his internship in Columbia Hospital of Richland County in Columbia in 1962.

Military service for Dr. Morrison embraced a period of two years at Fort Myers, Arlington, Virginia, where he was general medical officer in charge of a dispensary which served dependents of military personnel.

MEDICAL COLLEGE OF GEORGIA CONTINUING EDUCATION COURSE

MUSCULAR SKELETAL PROBLEMS IN CHILDREN—November 10-12, 1964.

Coordinator: Floyd E. Bliven, Jr., M. D., Professor, Surgery and Chief, Orthopedic Division.

Conference On Disaster Medical Care

The 15th Annual Conference on Disaster Medical Care will be held in Chicago, November 7-8, at the LaSalle Hotel. This conference is sponsored by the AMA's Committee on Disaster Medical Care and will provide discussions of many phases of the matters involved in disaster service.

The World Medical Association

The Association has begun the publication of a newsletter, "International News Items," which gives a resume of the activities of the Association. An increase in membership is greatly to be desired, and South Carolinians are urged to become active members.

W. B. SAUNDERS COMPANY features
the following new books in their full page
advertisement appearing elsewhere in this issue:

DOCTOR'S EASACCOUNT RECORD SYSTEM
New! — A financial record keeping system tailored specifically to the requirements of physicians.

HUGHES — PEDIATRIC PROCEDURES
New! — Step-by-step instructions on scores of management procedures for child patients.

BATES AND CHRISTIE — RESPIRATORY FUNCTION IN DISEASE
New! — A valuable aid in managing those patients suffering from lung conditions.

Report on Physician-Hospital Relations (American Medical Association). A Summary

"Advances in medical science and technology, the subdivision of knowledge and skills among physicians and paramedical personnel, research and education programs, dramatic growth of health insurance and prepayment plans—all of these have served to increase the role of the hospital in community health care.

"Public use of hospital emergency departments has expanded to the point where the majority of patients using these facilities have non-emergent problems. The resultant problems of providing adequate staffing and assuring true emergency cases prompt, definitive treatment are of increasing concern to administration, medical staffs and medical societies alike.

"Certain leaders in the field of hospital administration and public health conceive of the hospital not only as a facility for acute inpatient care but, also, as a logical focus for all-inclusive care—embracing the diagnosis and treatment of outpatients; rehabilitative and chronic (or long-term) care; and home care.

"Increasing numbers of hospitals are providing space for the examination and treatment of private outpatients and/or constructing physicians' office buildings adjacent to hospitals.

"To a significant degree physicians themselves have fostered the expanding role of the hospital in providing community health services. They rely on the facilities provided and encourage their expansion; they refer patients to out-patient departments and emergency rooms; they encourage teaching programs and the employment of physicians. In increasing numbers, they are centering their activities in and about the hospital.

"Public concern over the 'haphazard' development of hospital and other medical facilities in the massive building program following World War II has resulted in the development of areawide planning programs aimed at controlling construction and coordinating facilities and services. This development has been fostered by federal research experiment and demonstration grants authorized under the Hill-Burton Act. Proposed legislation would expand federal support by earmarking $22.5 million over a five-year span to support areawide planning agencies. Funds made available would be controlled by state Hill-Burton agencies.

"Such programs have so far been concerned mainly with controlling construction. The coordination of facilities and services, as conceived by some leaders in the planning movement, would require a regionally organized and integrated system.

"Attempts to impose regional affiliation have shown little success. However, one planning agency believes that future development will evolve through management affiliations and corporate mergers. Pressure for higher standards and more comprehensive service, it feels, will cause the newer, smaller hospitals to look to the older, established institutions for certain direct services and supervision.

"It is logical that physicians should play an important role in hospital planning. The House of Delegates of the AMA supports the principle of *voluntary* areawide planning and has urged medical societies and individual physicians to cooperate and exert leadership. However, physicians should be alert to legislation which would give planning agencies the power to compel compliance.

"The Committee on Medical Facilities has directed that a study be made from which can be developed a set of guidelines for physicians and medical societies participating in planning movements to foster the interests of the public and to preserve the voluntary system of health care."



The emergency medical identification symbol sponsored by the American Medical Association for universal use was adopted by the Assembly of the World Medical Association at their meeting in Helsinki, Finland, in June, 1964.

The resolution stated "that this symbol — be adopted by the World Medical Association as the universal medical information symbol, and that its use on identification tags, bracelets and cards be encouraged among the people of the world."

International travellers wearing the universal symbol as an indicator of their special needs in an emergency, will soon have it recognized for what it is in the 58 member nations of the WMA. This is a significant advance in international cooperation for health protection.

Information about the symbol and its use may be obtained from the American Medical Association.

Deaths

Dr. George R. Wilkinson

Dr. George R. Wilkinson of Greenville, a greatly beloved and trusted physician to a large professional clientele, a highly respected medical colleague, and a man admired by a host of friends in his community, passed away on August 30, 1964.

He had retired from practice some months before because of failing health, and he had been critically ill for some three months before his death.

His life was one of continuous effort in the betterment of medical practice, the maintenance of a good professional "image," and the furtherance of the objectives of organized medicine.

Dr. Wilkinson was born in 1891. He located in Greenville in 1920. He and a colleague, Dr. Hugh Smith, who came to Greenville about the same time, each began independently a new type of medical practice, as practice was then in South Carolina. Their offices were equipped for comprehensive studies of obscure and difficult conditions.

Dr. Wilkinson was elected to the Board of Medical Examiners of South Carolina some 25 years ago, and he had served since 1956 as its chairman. He was dedicated to an ideal of keeping the profession in South Carolina free from inroads of foreign and other physicians with inferior or questionable educational preparation or with alien attitudes toward the relationship between patient and physician.

Dr. Wilkinson was a charter member of the Greenville Medical Study Club. He was one of a group of prime movers which brought about the establishment of *The Bulletin* of the Greenville County Medical Society. For many years, he wrote a column for that publication which was famous for the wit and humor, which was interspersed among the news items and the constructive criticisms relating to the Greenville General Hospital.

Dr. L. M. Keach

Dr. L. M. Keach, of Greelyville, died unexpectedly at his office September 3.

Dr. Keach was born April 21, 1928 in Vallejo, Calif. He was educated at The Citadel, and attended Bowman Gray School of Medicine, where he received his degree. He had been practicing medicine in Greelyville since 1960.

Dr. Dunbar Hammond

Dr. Dunbar Hammond, 81, died at his home in Blackville.

Dr. Hammond was a graduate of the Medical College of South Carolina and had practiced medicine in Blackville for 56 years. He was an Episcopalian.

Book Reviews



FUNDAMENTALS OF OTOLARYNGOLOGY, by L. R. Boies, J. A. Hilger, and R. E. Priest. Fourth Edition. W. B. Saunders Company, Philadelphia & London. 1964. Pp. 553. $8.50.

This compact, concise textbook is much more complete than its size would lead you to believe. Its method of presentation is clear and orderly, and the arrangement of the sections is logical and makes the subject matter easily understood.

This book is an ideal one for both the general practitioner and the specialist, and a very desirable one for both medical students and residents.

The authors are to be congratulated on an excellent presentation.

R. W. Hanckel, M. D.

GRANDPARENTS AND THEIR FAMILIES, by Frank Howard Richardson, M. D. David McKay Company, Inc., New York. 1964. Pp. 112. $3.50.

This latest work of Dr. Richardson is a fitting sequel to his previous volumes which discuss "The Nursing Mother," "For Girls Only," "For Boys Only," "For Parents Only" and others.

Even though today much attention is focused on youth, and properly so, yet latterly grandparents have become far more numerous and also more important. People now live longer and old folks are more vigorous than formerly.

Richardson should know something of the problems of grandparents for he and his wife Clara, at the latest counting had twelve grandchildren.

This brand-new very practical book, which is a guide, has 23 chapters and an index. In the preface it is admitted that being a grandparent is a "tricky business" and that it does have problems, yet it is worthwhile and rewarding.

Some of the chapters may be read with considerable benefit by grandparents. Several chapters, especially No. 5, Things for Grandparents to Know; No. 6, What a Child Should Expect from Grandparents; No. 13, Don'ts for Grandparents; No. 17, Married Children Living with Their Parents; particularly appeal to me, but tastes differ.

This volume is easy to read for its style is colloquial and there is some dialogue. It contains much practical information or perhaps advice for loving grandparents who often do not realize that love alone is not sufficient and that they have had their day. The author tells them that they must refrain by word or deed from interfering in the rearing of their grandchildren.

This volume has clear print, the paper is good, the binding and board covers are excellent.

In essence, one can truthfully say that the outstanding characteristics of this guide are the knowledge exhibited, partly based on experience, its practicality, along with sincerity and sympathy.

R. M. Pollitzer, M. D.

PEDIATRIC THERAPY, Edited by Dr. Harry C. Shirkey. C. V. Mosby Company, St. Louis. 1964. Pp. 1104. $16.50.

The book is divided into 19 major sections. The first two sections on drug treatment and treatment of symptoms, respectively, and the final section entitled "Table of Dosages" are written entirely by Dr. Shirkey, and are very worthwhile reading for undergraduate as well as post-graduate students.

Dr. Shirkey has also written many of the sections in the other parts of the book or has been co-author of many of them; his effort has been much more than that of an editor or compiler.

There is a section on general therapy and therapy of medical disease (chiefly infectious diseases) and there are sections on each of the major systems and medical and surgical subdivisions. The list of 72 contributors includes many of the most respected pediatric researchers and educators in the country. Each is a qualified authority on the subject which he has undertaken to write.

All of the important common pediatric conditions and a great many of the rare and exotic problems are discussed very concisely, with emphasis on the differential diagnosis and the laboratory and clinical work-up of the problem, followed by detailed discussion of the various modalities of therapy that are applicable. The book is very liberally illustrated with excellent drawings, pictures, charts and tables. The book is very nicely bound and organized with a very complete index and with appropriate references and guides to further reading following each section.

It is fortuitous that this very excellent and timely book was released just a few months after another very similar and also very excellent book on the same subject. Many pediatricians will have trouble deciding which of these two books they should get. In many instances there is excellent discussion of some, perhaps, obscure problem in one book and not in the other; whereas, another rare and unusual situation might be treated much more adequately in the other. Perhaps, for these reasons, the pediatrician should have both volumes in his office, so he can get the advantage of different authoritative slants and ideas, particularly in regard to the many clinical problems of uncertain cause, and where there is honest controversy regarding the best method of treatment.

There has long been a need for an up to date reference on pediatric therapy. We now have a feast instead of a famine. Dr. Shirkey is to be congratulated on this monumental undertaking which has been accomplished with such brilliant success.

J. R. Paul, Jr., M. D.

THE CIGARETTE HABIT: AN EASY CURE, by Arthur H. Cain. Doubleday & Company, Inc., Garden City, New York. 1964. Pp. 106. $.95.

There are probably now as many books and articles on the control of the cigarette habit as there are on the reduction of high cholesterol levels. This short paperback book offers what the author thinks is a successful, though not necessarily easy cure for the smoking habit. The psychological approach is offered along with a step-by-step guide to the happy day when cigarettes will be no more.

J. I. W.

INTERNAL MEDICINE IN WORLD WAR II. Volume II. Infectious Diseases. Office of the Surgeon General, Department of the Army, Washington, D. C. 1963. Pp. 649. $6.75.

This volume, another in the series describing the experiences of the United States Army Medical Department during the second World War, confines itself to a consideration of a number of infectious diseases of importance during that conflict. Not intended as a textbook of infectious diseases, this publication is still of value to the student in his study of the history of a specific infection. In many instances, studies which led to an understanding of the epidemiology and actual cause of these diseases were conducted under the trying conditions of combat, and these make interesting reading. To those specifically interested in this specialty, this book is a useful possession. Much space is devoted to infections less commonly seen in this country such as sandfly fever, dengue and the typhus fevers while other important infections are not included. Considerable repetition makes cover-to-cover reading difficult. Still these accounts of many important global infections, each written by an author having first-hand experience during the war, represent a valuable contribution to our knowledge of disease.

Louis P. Jervey, M. D.

MEDICAL DEPARTMENT, UNITED STATES ARMY — SURGERY IN WORLD WAR II — ACTIVITIES OF SURGICAL CONSULTANTS VOLUME II. Editor in Chief Colonel John Boyd Coates, Jr., MC, USA. For sale by Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. $8.50.

This volume is an account of the activities of surgical consultants in overseas theaters of operations, excluding field armies. The experiences recounted are highly instructive and will be invaluable to future overseas consultants.

There was some opposition to the consultants at first, but, in view of their competent performance, the animosity gradually died away.

The consultants occupied themselves not only with clinical matters but also with a variety of related administrative matters. They evaluated the qualifications of personnel and advised their assignment. They planned specialized treatment centers, and provided blood for forward casualties. Surgical and shock teams were added to normal hospital complements so that hospitals could function on a 24 hour basis when required. Courses of instruction were conducted to emphasize the correct initial management of wounds. Special studies were made in regard to the care of abdominal wounds, thoracic wounds, and other regional wounds. Great stress was placed on the proper triage of casualties to increase survival and to decrease morbidity and permanent deformity.

The consultants were untiring in their efforts, they were dedicated to their work, and their accomplishments were magnificent. The manner of their performance demonstrated to the Army the necessity for establishment of a permanent consultant system. This has been accomplished, and is now an integral part of the Army Medical Department.

O. S. Reeder, M. D.

MODERN TREATMENT. Vol. 1, No. 1, Jan. 1964. Treatment of Renal Disease. Guest Editor, E. Lovell Becker; Treatment of Thyroid Disease, Guest Editor Edward A. Carr, Jr., M. D. Hoeber Medical Division, Harper & Row, Publishers, New York 16, N. Y. $16.00.

This is the first issue of a new publication planned for the purpose of helping the practicing physician keep up with the trends and progress of present day therapy of disease. It is designed as a bi-monthly publication, paperback, is organized as symposia with a guest editor and chapters by physicians who are recognized authorities in their respective fields. Each issue is planned to cover treatment in one or more important areas.

The first issue covers the treatment of renal disease and the treatment of thyroid disease. Contributors to the symposium on renal disease include Drs. George Schreiner, David P. Earle, Cheves McC. Smythe, and others. Among the subjects discussed are treatment of acute renal insufficiency, chronic renal insufficiency, glomerulonephritis, pyelonephritis, peritoneal dialysis and hemodialysis, diuretics in renal disease, the nephrotic syndrome and the nephritis of systemic lupus.

The symposium on thyroid disease includes articles on the management of hypothyroidism during infancy and childhood, treatment of hypothyroidism, treatment of Hashimoto's disease and invasive thyroiditis, treatment of granulomatous thyroiditis, of thyrotoxicosis, and of malignant disease of the thyroid. Contributors include Drs. Jacob Lerman, P. G. Skillern, and others.

Chapters on the various subjects are restricted almost entirely to discussion of treatment programs. They are well written, complete and are of sufficient clarity for easy reading. Discussions of the physiologic basis for treatment add much to the usefulness of the volume as an up-to-date detailed reference text for the management of illness. While the material presented is available from other sources, its collection and organization in a single volume is a distinct advantage as a ready reference for the practicing physician. Though changes in therapy make parts of such a publication rather quickly obsolete at times, the general principles and rationale of therapy as discussed make the volume a worthwhile addition to the physician's library.

Kelly T. McKee, M. D.

REVIEW OF MEDICAL PHYSIOLOGY, William F. Ganong, M. D. Lange Medical Publications. Los Altos, California, 1963. $6.50.

Although designed, according to its author, as "a concise summary," this review occupies 555 pages of rather small type. Considered strictly as a review, and not as a textbook, the work is outstanding, being well balanced, clearly written, about as up-to-date as possible, surprisingly comprehensive in its coverage of concepts, and illustrated by an excellent choice of figures from the original literature. The principal reservation harbored by this commentator is that the book is sufficiently impressive to tempt its misuse by students as a substitute for, rather than as an accessory to, standard, full length textbooks of physiology. Nevertheless, in the role of review designated by its author, this is, indeed, a valuable contribution.

T. G. Bernthal

DIET AND BODILY CONSTITUTION. Ciba Foundation Study. Edited by G. E. W. Wolstenholme. Little Brown and Company, Boston. 1964. Pp. 120. $2.95.

A colloquium on the effects of early nutritional status on growth, mentality, longevity and other phases of development which offers discussions and pertinent questions by high authority, but no firm conclusions.

JIW

MINUTES
SOUTH CAROLINA MEDICAL ASSOCIATION*
116TH ANNUAL SESSION
HOUSE OF DELEGATES
OCEAN FOREST HOTEL MYRTLE BEACH, S. C.
MAY 5-6, 1964
ROBERT WILSON, M. D., Presiding

11:30 A. M.—Wednesday, May 6, 1964, Annual Elections.

The Chair: Will the House of Delegates come to order. The Chair will recognize Dr. Tucker Weston.

Dr. Weston: Gentlemen and ladies, I think that last night and yesterday afternoon we had the opportunity of listening to one of the most articulate, forthright, dynamic and forceful speakers, representing American medicine, in our memory. I would like to make a motion that the President of the South Carolina Medical Association have prepared a proper resolution stating these facts and forwarding it to Dr. Annis, thanking him for the tremendous job that he has done for American Medicine in his year as president and his service to the American Medical Association. We would like to also thank him for visiting our convention.

Third, I would like the South Carolina Medical Association to go on record as requesting the Legislature, in joint session, in its next session next January, to extend to Dr. Annis the privilege of addressing that joint session with the backing and request of the South Carolina Medical Association. I talked with Dr. Annis last night and he said he would be most happy to make an appearance to the Legislature, if such could be arranged. So I make that in the form of a motion in those three parts:

Thanking him for the work he has done as president.

Thanking him for being with us and addressing us.

Requesting the speaker of the house and the Lieutenant Governor, the presiding officer of the senate to see if they can give him a joint session audience in the next legislative session.

The Chair: I will call for adoption of the resolution by acclamation. I will rule as presiding officer that I will take part of the first two sections of the resolution and leave it to the incoming president and Council to put into effect the extension of an invitation to the legislature.

I would now like to ask for a resolution extending thanks of the Association to all of those who have had part in the planning and execution of this meeting, including the Executive Secretary and staff, the management of the hotel, and to all participants in the House of Delegates—would someone make such a motion?

The Chair: I don't think this is controversial and I ask for its adoption by acclamation. (This was done.)

Now, the Chair would like to have the report of the Credentials Committee, Dr. J. W. Wyman, Chairman, as to the number of delegates here present.

Dr. J. W. Wyman: Mr. President, we have a total of 106 eligible to vote, this includes 28 officers and past presidents and 78 elected delegates.

The Chair: The Chair will ask the tellers to be cognizant that we have only 106 voters and we don't want 108 votes.

The first order of business will be nominations for the office of President-Elect of the association.

Dr. J. Howard Stokes (Recognized by The Chair): Mr. President, fellow members of the House of Delegates, I am Howard Stokes of Florence. I represent for the moment Florence County and it is with a great deal of pleasure and pride that I place in nomination for President-Elect of this Association next year the name of Dr. Julian P. Price. Dr. Price, for some of you younger members who have not known him as well as some of the older, was born in 1901 in China, did his undergraduate education at Davidson College, his graduate training in Johns Hopkins, his internship at Hopkins, his residency at John Hopkins and New York. He moved to Florence where he has been a practicing pediatrician since that time. In 1941 he became very active in state medical affairs, was Secretary, Treasurer and Editor of the Journal for ten years, in 1952 he was elected delegate to the AMA, in 1954 he was elected to the Board of Trustees, he served ten years, two years as vice-chairman and his last year as Chairman. He was also for ten years on the Joint Accreditation Committee of the AMA, and serving as Chairman for the last two years. I have other things I could tell you about Dr. Price. There are things many of you ought to know. He is extremely active in community affairs, he is a past president of the Kiwanis Club, a deacon in the Presbyterian Church and is now an active member of the school board. It is with great pride and pleasure that I present to you the name of Dr. Julian P. Price, as President-Elect of this Association.

Dr. Johnson: I knew I couldn't get to him to stop him. (Laughter) Yesterday Dr. Price and I were sitting in the back of the room and he said "You know, when I became Secretary and Treasurer and Editor and Executive Secretary, we had $2,000.00 in the bank and the annual dues were $6.00 a year." And he said, "My, how this association has grown."

As one who has known and loved Julian Price for 34 years, I am delighted to second him for the office of President-Elect.

(The vote was taken, it was unanimous, there being no noes.)

The Chair: Dr. Price is elected as President-Elect. I will ask Dr. Stokes and Dr. Wes Simmons to escort Dr. Price to the stand.

While we are waiting for Dr. Price—nominations are now in order for Vice-President of the Association.

Dr. Howard Gilmore: Mr. President, I would like to nominate for Vice-President of the South Carolina Medical Association Dr. Swift Black, of Dillon.

*This is an edited version of the minutes in which some of the routine parliamentary procedures and customary amenities have been omitted for lack of space. The verbatim copy of the proceedings is in the hands of the Secretary.

The Chair: Is there a second to Dr. Black's nomination?

Dr. Evatt: I second the nomination of Dr. Black, and move that nominations be closed and that Dr. Black be elected by acclamation.

(The vote is taken and passed.)

(Dr. Price comes into the room, escorted by Dr. Stokes and Dr. Simmons. The House applauds and rises while Dr. Price goes up on the rostrum.)

The Chair: I followed Dr. Price in the office of Secretary and now I am glad that I preceded him as President. We couldn't have a better man on the job.

Dr. Julian P. Price: Little did I know when I joined the Association 35 years ago—I sat in the House for the first time 30 years ago—that in the year 1964 I would have two body guards helping me up here.

I owe a great deal to the South Carolina Medical Association for which I am truly grateful. They allowed me to serve in the House, here, on Council and as Secretary and Treasurer and Editor, and then they gave me the privilege of representing the state on the national level. And it is remarkable how our Association has changed. As I heard the report, yesterday, I remember when I came in as Secretary in 1941, I was the Secretary, Treasurer, the Executive Secretary and the Editor and the entire cost of my office, including all the secretarial help and stenographic help I had, was $3,000.00 a year. The annual dues were $6.00 a year and the only assets that we had at that time were $2,000.00 which were in a defunct bank in Seneca. So times have changed tremendously as we have listened to reports to the House, at this time, we see how much there is for us to do. As we heard Dr. Annis last night we realize what a tremendous challenge is before us, as an association, on the state and on the national level. And to be elected president-elect of this Association puts you in a rather difficult position. I feel a little like the psychiatrist I heard of lately—it seems there were these two psychiatrists who always got on the elevator in the morning together. The little short, fat, baldheaded one had his office on the eighth floor. The tall, skinny one had his office on the third floor, and each morning when they got in the tall one would turn around and spit on the head of the short one and then get off on the third floor. The elevator boy stood it for four or five mornings and finally he turned to the short dumpy fellow and said "Will you just tell me why it is that this other man always spits on your head in the morning?" The fellow said "I don't know, but I feel he must be confused." And I think that is the way that you feel when you are elected to an office like this. And I am reminded of one of the old Proverbs "Big outcry, little outcome." I think that is what every elected officer should start out with "Don't brag, get to work." So, from the bottom of my heart I want to thank you for the honor you have given me and I hope that I can follow along in the train of the wonderful men we have had as presidents of the Association over the years. Thank you.

The Chair: Thank you, Julian, very much.

Dr. Price has told me, privately, that while he would like to go back to the $6.00 a year dues he doesn't think he can do so next year. (Laughter)

Nominations are now in order for Secretary of the Association.

Dr. William Weston, Jr. (Recognized by the Chair): I would like to place in nomination the name of Dr. Ben N. Miller, who has been serving as our secretary for the last few years. Dr. Miller is not at this convention because of illness—oh, he is here. He had a very sick niece in Columbia and I am delighted to see he is here. That is why his report was read yesterday. I think you all know Dr. Miller's qualifications, I am not going to go into them in detail, but I would like to place his name in nomination for the office of Secretary.

The Chair: Before we put this to a vote, are there any further nominations, if not Dr. Holmes' motion that Dr. Miller be elected by acclamation is in order. (The vote was unanimous.) All right, I ask Dr. Miller to come up here and sit where he is supposed to sit.

For the office of Treasurer, the Chairman of Councill will present the nominee of Council, Dr. Burnside.

Dr. A. F. Burnside, Chairman of Council: Mr. President and members of the delegation, according to the rules it is Council's privilege to nominate the Treasurer to the House of Delegates. We have a treasurer who has been faithful with us for many years and Council takes pleasure in nominating Dr. Howard Stokes.

The Chair: Don't get away too far, Dr. Burnside, I have another question for you.

I don't think it is in order for any other nominations, so the Chair will rule that Dr. Stokes is elected by acclamation.

For the office of Delegate to the American Medical Association, the term of Dr. George Dean Johnson expires at the end of this year. Dr. Johnson is eligible for re-election. Are there nominations?

Dr. E. M. Colvin: I would like to nominate Dr. George Dean Johnson to succeed himself. (There were many seconds)

(The vote was taken, it was unanimous.)

The term of the alternate delegate to the American Medical Association, Dr. Charles N. Wyatt expires December 31, 1964. Are there nominations?

(*Doctor from the Floor*): Dr. Wyatt has asked that he not be re-elected this year for a number of reasons. We all know that he served long and well and has contributed a lot of time and effort and we are indebted for that. I think we should go along with his idea of not being re-elected. I would like to place in nomination the name of Dr. Thomas Parker, a member of the Greenville County Medical Society. Dr. Parker has probably devoted more time and energy to things non-medical than any man of my acquaintance. He probably knows more of the workings of our national Congress than any man of my acquaintance. He is a real bird dog, he knows about all the bills, medical and non-medical. I think he would really serve us well, and do a wonderful job and I would like you to consider him as alternate delegate to the AMA.

The Chair: Is there a second to Dr. Parker's nomination?

Dr. H. S. Gilmore: I second his nomination.

(The vote was taken, it was unanimous.) The Secretary shall cast a unanimous ballot for Dr. Tom Parker as Alternate Delegate to AMA.

The Chair: Councilors: (3-year terms) The 2nd District—The Term of Dr. A. F. Burnside expires, and having served three consecutive terms is ineligible for re-election.

Dr. L. V. Jowers, Columbia, (Recognized by The Chair): Mr. President, I would like to place in nomination the name of P. F. LaBorde, Jr., of the Columbia Medical Society.

The Chair: Are their further nominations?

Dr. Sam Garrison: Mr. President and members of the House of Delegates, I am Sam Garrison from the Johnston Medical Society, it gives me great pleasure to nominate for this most important position a fellow

member of a great medical society who has demonstrated his many capabilities through the years by serving in various capacities in the numerous medical organizations. This man, I am sure, will serve well on Council, he is a man of understanding and good judgment. It gives me great pleasure to nominate Wyman King from Batesburg. (This nomination of Dr. King was seconded by Dr. Mayer, and also Dr. George Dean Johnson. (Dr. King was elected.)

The term of Dr. John M. Pratt of the Fifth District. He is eligible for re-election. Are there nominations?

Dr. H. Z. Hildebrand: I would like to place in nomination the name of Dr. Roderick Macdonald, of Rock Hill. He is one of the past presidents of the state Association, he has been drafted by the York County Medical Society for this post and the other societies in our district are backing Dr. Macdonald in this position and we would like to nominate him for Councilor from the Fifth District.

Dr. Alton G. Brown: Mr. President, members of the House of Delegates, the York County Medical Society strongly feels that the councilor from a district should be selected and drafted and recommended by that District. At the last meeting of the York County Medical Society, in consultation with other Medical Societies in our District, we voted without dissenting vote to nominate Dr. Macdonald, and I would like to second that nomination.

(The vote was unanimous.) (Dr. Macdonald was elected Councilor from the 5th District.)

The 8th District—The term of Dr. J. D. Thomas expires, and Dr. Thomas is eligible for re-election.

Dr. Neil C. Price, of Orangeburg (Recognized by The Chair): Mr. President I would like to nominate Dr. Thomas to succeed himself. (Dr. Gressette and Dr. Black seconded Dr. Thomas' nomination. Dr. Thomas was elected.)

Mediation Committee Members: 3-year Terms, The Council nominated two men from each of the three districts:

2nd District—The term of Dr. Wm. H. Bridgers expires.

5th District—The term of Dr. Ripon W. LaRoche expires.

8th District—The term of Dr. James L. Wells, expires.

These men are all eligible for re-election. Dr. Burnside, will you give us Council's nominations?

Dr. A. F. Burnside, Chairman of Council: Mr. President, and Members of the House Delegation, Council nominates two men for one position; for the Second District Council nominates:

Dr. Garrison Latimer, from Lexington County
Dr. John A. Poda, from Aiken County

For the Fifth District, Council nominates:

Dr. Ripon W. LaRoche, from Kershaw
Dr. John N. Gaston, from Chester

For the Eighth District, Council nominates:

Dr. James L. Wells, from Orangeburg
Dr. Henry W. Gibson, from Barnwell County.

The Chair: You will prepare your ballots for the election of one of these, as a member of the Mediation Committee from the 2nd District, the 5th District and from the 8th District.

The Benevolence Fund Committee—a 3-year term.

The Term of Dr. T. G. Goldsmith expires and I understand he is not eligible to be re-elected at this time. Do I hear a nomination? Is there a nomination? If you don't nominate someone Dr. Goldsmith is there until we elect a successor.

Dr. Black: Since you have ruled, and since Dr. Goldsmith has done such a good job, I move the nominations not be opened further.

The Chair: The Chair rules that a member to an elected office continues until his successor is chosen, so Dr. Goldsmith, you are elected.

Members of the State Board of Medical Examiners —4-year terms, to be nominated by the House of Delegates, and commissioned by the Governor. The Member-at-large—the term of Dr. H. E. Jervey, Jr., expires.

Dr. George Wilkinson (Recognized by The Chair): Mr. President, I would like to place in nomination the name of Harold E. Jervey, Jr. Harold Jervey has been on the Board for several terms. At the present time Dr. Jervey occupies a commanding position in the national group of the local Boards of Examiners. His experience with the national body has given us much prestige and has, I think, created a better standing for our Board for anything that we want done. It is a great pleasure to have somebody on our Board who knows practically every secretary of the boards in all the states. It is a great deal of pleasure, also, and satisfaction to have somebody on the Board who has given a great deal of time and effort and who is capable and who has standing at the national level. I hope that we will be able to send him back to the Board for another four-year term.

Dr. Holmes: I would like to second the nomination that Dr. Wilkinson made of Dr. Jervey. I consider him a credit to the profession and to the Board of Medical Examiners.

Dr. William Weston (Recognized by The Chair): I second the nomination of Dr. Wilkinson for Dr. Jervey to succeed himself, and I second what Dr. Wilkinson and Dr. Holmes have said in regard to Dr. Jervey. He is an outstanding individual, he is recognized nationally and he is doing the duty which he has been elected to do and he will go on and continue to do it, if we re-elect him. He is a man of astuteness and soundness and I take great pleasure in seconding the nomination.

The Chair: Are there further nominations?

Dr. P. F. LaBorde, Jr.: Even in the face of such overwhelming endorsement, I would like to place in nomination the name of Dr. E. W. Masters, of Columbia.

(Dr. Jervey was elected.)

For the Sixth Congressional District—the term of Dr. H. S. Gilmore expires.

Dr. Joe Cain: Members of the House of Delegates, I would like to place the name of Dr. H. S. Gilmore in nomination to succeed himself. Only those of us who are close to him in the sixth district know how much time he devotes to the Board of Medical Examiners and it is well to keep men with such devotion to duty on the Board as long as we can. I certainly hope that you will approve of my nomination.

The Chair: Are there further nominations?

The Chair: There are no further nominations. Dr. H. S. Gilmore is elected to succeed himself as a member of the State Board of Medical Examiners, from the Sixth Congressional District.

Members of Hospital Advisory Council to State Board of Health—4-year terms.

The term of Dr. Roderick Macdonald expires and that of Dr. Belton J. Workman. Do I hear nominations?

Dr. Sam Fleming, of Spartanburg: (Recognized by The Chair) I would like to place the name of Dr. Belton J. Workman in nomination for re-election.

The Chair: Dr. Workman has been nominated for re-election. Are there further nominations? This is an important committee and we don't want to leave any vacancy.

(From the Floor) I would like to nominate Dr. Roderick Macdonald to succeed himself.

Dr. Roderick Macdonald: Mr. President, I have



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served on that committee since its origin and I appreciate the nomination but I would beg the gentleman who nominated me to withdraw my name, I think it is time for somebody else to serve on this council.

The Chair: Dr. Macdonald's name has been withdrawn.

Dr. O. B. Mayer: I would like to nominate Dr. Ralph Baker of Newberry. (This was seconded by Dr. Kilgore.)

The Chair: Dr. Ralph Baker has been nominated, are there any further nominations? (Dr. Baker was elected.)

The Chair directs the Secretary to cast the ballot for Dr. Ralph Baker and Dr. Belton J. Workman as members of the Hospital Advisory Council to the State Board of Health.

Members of Committee on Legislation and Public Relations—3-year terms to be nominated by Council and elected by the House.

The Chair: The terms of Dr. Donald G. Kilgore and Dr. C. Tucker Weston expire. Dr. Burnside, Chairman of Council.

Dr. A. F. Burnside, Chairman: Mr. President, and members of the House of Delegates, Council nominates Dr. Donald G. Kilgore and Dr. Tucker Weston to succeed themselves.

The Chair: The nominations are closed, I don't believe we can have nominations from the floor for this committee and the Chair rules Dr. Kilgore and Dr. Weston are elected by acclamation.

Members of Committee on Emergency Medical Care—5-year term, to be nominated by Council and elected by the House.

The Chair: The term of Dr. J. Graham Shaw expires.

Dr. A. F. Burnside, Chairman of Council: Mr. President and Members of the House of Delegates, Council nominates Dr. J. Graham Shaw to succeed himself.

The Chair: Dr. Shaw is nominated to succeed himself. Since there are no further nominations, the Chair rules that Dr. Shaw is elected by acclamation.

While we are waiting for the tellers report, Dr. Ben Miller has asked to be recognized, Dr. Miller.

Dr. Ben N. Miller, Secretary: Robert misunderstood, I didn't ask to be recognized. I would like to be excused for delinquency, for my failure to be here as your Secretary, anyway it was a real important thing, illness in the family. I am glad to be here, I see old friends in the audience and it makes my heart real warm to be among you again. Thank you.

While I am talking I would like to perform a very nice and pleasant task, as far as I am concerned, Dr. Robert Wilson is at the end of his tenure of service as President and I would like to present a certificate from the Society as a token and with a word of thanks to him. (handing Dr. Wilson a certificate) (Applause)

The Chair: Thank you Dr. Miller. Is Dr. Bozard here?

Dr. Ben Miller: Dr. Bozard has been our Vice-President this year and it gives me a great deal of pleasure to present this certificate to him.

Selection of Place for 1965 Annual Meeting.

The Chair: While we are waiting for the report of the tellers, the next order of business is the selection of a place for our 1965 annual meeting. The time of the meeting is designated by Council, the House of Delegates has the decision as to where the meeting shall be held.

We have invitations from Dr. Frederick E. Nigels "The Horry County Medical Society has instructed me to issue to the House of Delegates a hearty invitation to return to Myrtle Beach."

We have an invitation from the Ocean Forest Hotel, Myrtle Beach.

We have an invitation from the Wade Hampton Hotel in Columbia, and from the Francis Marion Hotel, the Jack Tar Hotel, in Charleston.

What is the pleasure of the House?

Dr. Gaines: I move we come back to Myrtle Beach again next year. (This was seconded)

The Chair: Are there any other suggestions? If not, all in favor of coming back to Myrtle Beach, please stand. (Everybody stands) All opposed stand (There was no negative vote.) It is decided we shall return to Myrtle Beach next year at a time designated by Council.

Dr. Goldsmith: Mr. President, if I am not out of order, may I have the floor?

The Chair: Dr. Goldsmith of Greenville recognized.

Dr. Goldsmith: I would like to announce a meeting of the Benevolence Fund immediately after adjournment, and I thank the House of Delegates again for re-electing me. I am not sure that I was eligible but just the same I will put forth every effort to carry on as I have in the past. Thank you.

The Chair: Thank you, Dr. Goldsmith.

I have been asked to announce the tickets for the SCALPEL dinner are not selling quite like hot cakes and all who can and will are requested to come to hear Representative Herlong, and don't forget to get your tickets.

Dr. Tucker Weston (Recognized): I would like to put in a plug for SCALPEL. Dr. Peeples reported today there are 197 members of SCALPEL in South Carolina out of the 1800 doctors and their wives. I think it behooves all of us to get behind this movement. This is a non-partisan movement to pick whatever candidate is favorable to medicine, whether it is a democrat or a republican, and it certainly behooves all of us to get behind it and support Dr. Peeples and his Committee in SCALPEL.

The Chair: I will ask Dr. Evatt to escort Dr. Swift Black to the floor to be recognized as the newly elected Vice-President. (Dr. Black comes forward with Dr. Evatt amid applause.)

Dr. Swift Black: It is a real distinct honor you have afforded me and I pledge you my best. It is a pleasure for me to carry this honor back to the Pee Dee section of the state and to Dillon County, particularly. Thank you.

Tellers Report on election:

For the Second District—Dr. Garrison Latimer of Lexington County is elected as a Member of the Mediation Committee.

For the Fifth District, Dr. Ripon W. LaRoche is re-elected, and

For the Eighth District, Dr. James L. Wells is likewise re-elected.

If there is no further business a motion for adjournment is in order.

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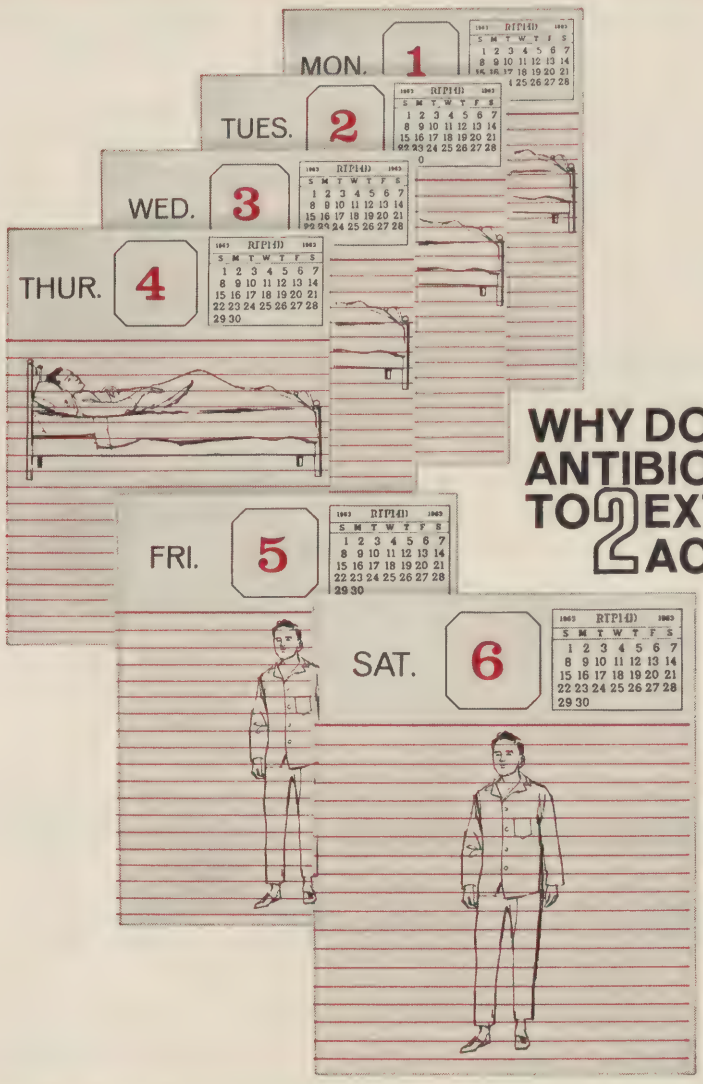
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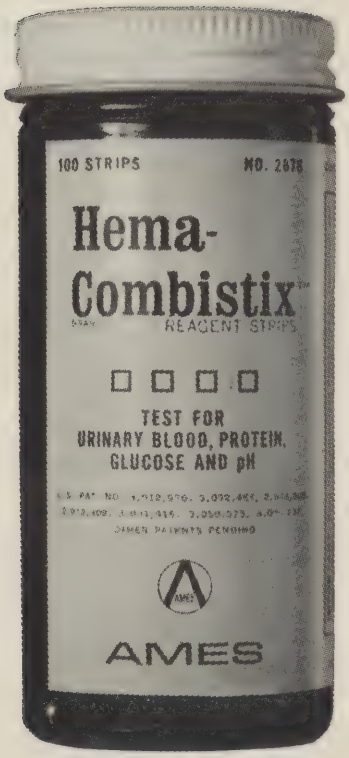
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*Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958.

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Abscess, pulmonary	17	16
Bronchiectasis	19	13
Bronchitis	286	267
Bronchopneumonia	192	179
Empyema	12	11
Pneumonia, lobar	150	146
Pneumonia, other febrile	160	150
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Chattas, A. et al.: Antibiot. Med. 7:300, May, 1960.

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Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

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Condition	No. of Patients	No. Cured with Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

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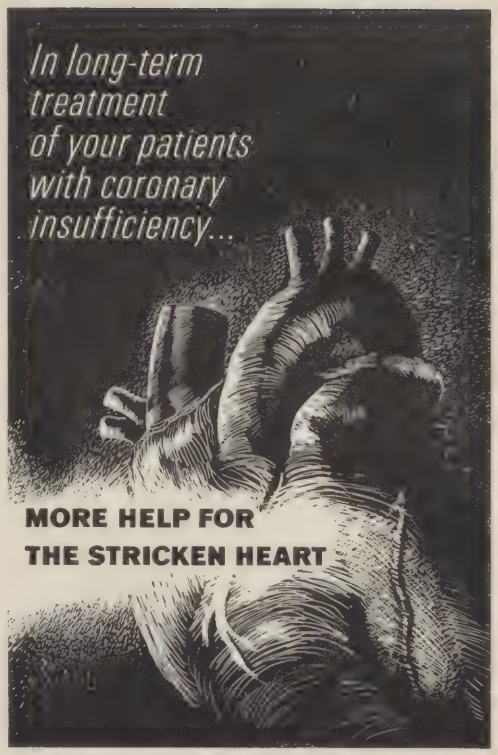
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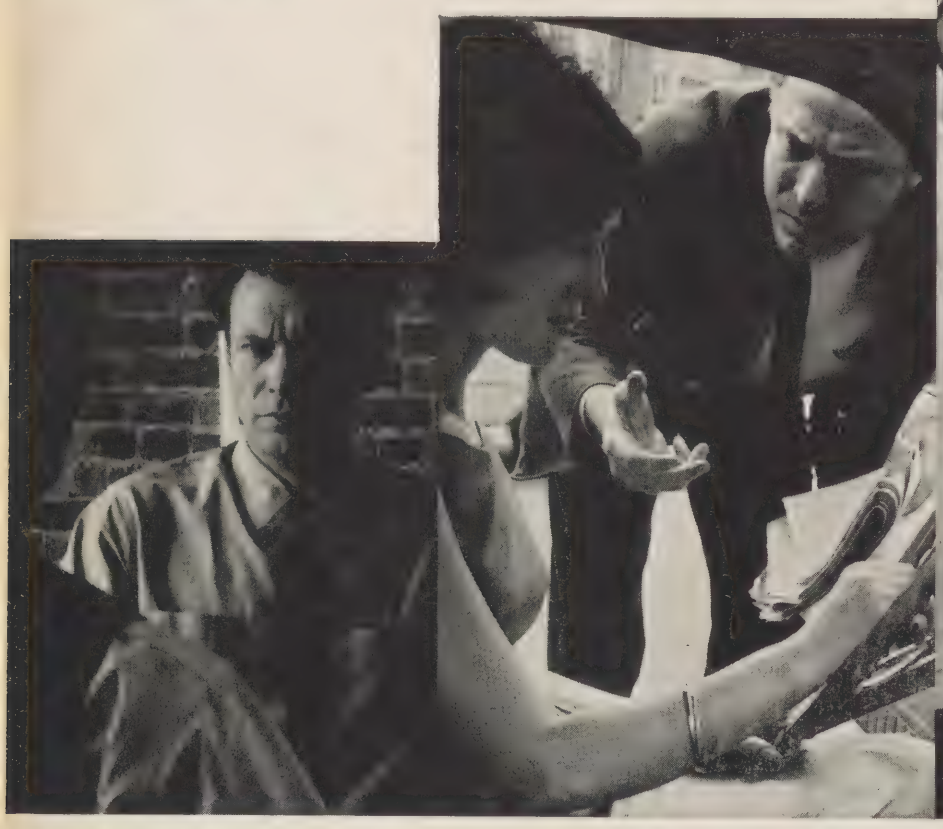

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alium (diazepam) may also be useful in acute agitation due to alcohol ithdrawal.

alium (diazepam) may be of use to alleviate muscle spasm associated ith cerebral palsy and athetosis.

osage and administration	*Usual daily dose*
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evere psychoneurotic reactions: Where severe nxiety, fear, agitation, aggression or hostility ex-t alone or with depressive symptoms	5 mg to 10 mg, 3 or 4 times daily
lcoholism: As an aid in symptomatic relief of cute agitation, tremor, impending or acute de-rium tremens and hallucinosis	10 mg, 3 or 4 times during the first 24 hours; reducing to 5 mg, 3 or 4 times daily as needed
Muscle spasm associated with cerebral palsy or thetosis	2 mg to 10 mg, 3 or 4 times daily

ontraindications: Valium (diazepam) is contraindicated in infants, pa-ents with a history of convulsive disorders or patients with a history of laucoma.

Varning: Valium (diazepam) is not of value in dealing with psychotic atients manifesting anxiety and should be avoided when there is reason o believe the patient is psychotic.

recautions: In elderly or debilitated patients, it is important to limit the osage to the smallest effective amount to preclude the development of taxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, o be increased gradually as needed and tolerated). As is true of all NS-acting drugs, until the correct maintenance dosage is established, atients receiving Valium (diazepam) should be advised against pos-ibly hazardous procedures requiring complete mental alertness or hysical coordination. Driving an automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam)—particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

Since Valium (diazepam) has a central nervous system depressant effect, patients should be advised against the simultaneous ingestion of alcohol and other central nervous system depressant drugs during Valium (diazepam) therapy. Safe use of Valium (diazepam) during pregnancy has not been established. The usual precautions are indicated when Valium (diazepam) is used in the treatment of anxiety states where there is any evidence of impending depression; particularly the recognition that suicidal tendencies may be present and protective measures may be necessary. The usual precautions in treating patients with impaired renal or hepatic function should be observed.

Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (*e.g.,* convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

Paradoxical reactions, such as excitement, depression, stimulation, sleep disturbances, acute hyperexcited states and hallucinations have been reported. Other side effects noted have been blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash.

Valium (diazepam) is available as 5-mg and 2-mg tablets. For convenience and economy in prescribing, both strengths are supplied in bottles of 50.

Roche Laboratories endorses the principle of caution in the administration of any therapeutic agent to pregnant patients.

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The Journal of The SOUTH CAROLINA Medical Association

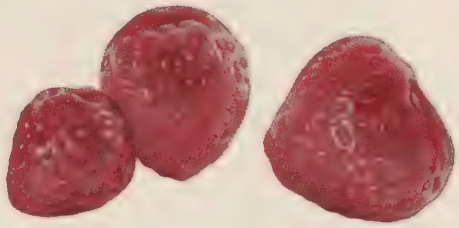
Hypertensive Renal Diseases
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Automobile Fatalities
Thomas Brockman, M. D.
Army Reserve Program

OLUME 60 NOVEMBER 1964 NUMBER 1

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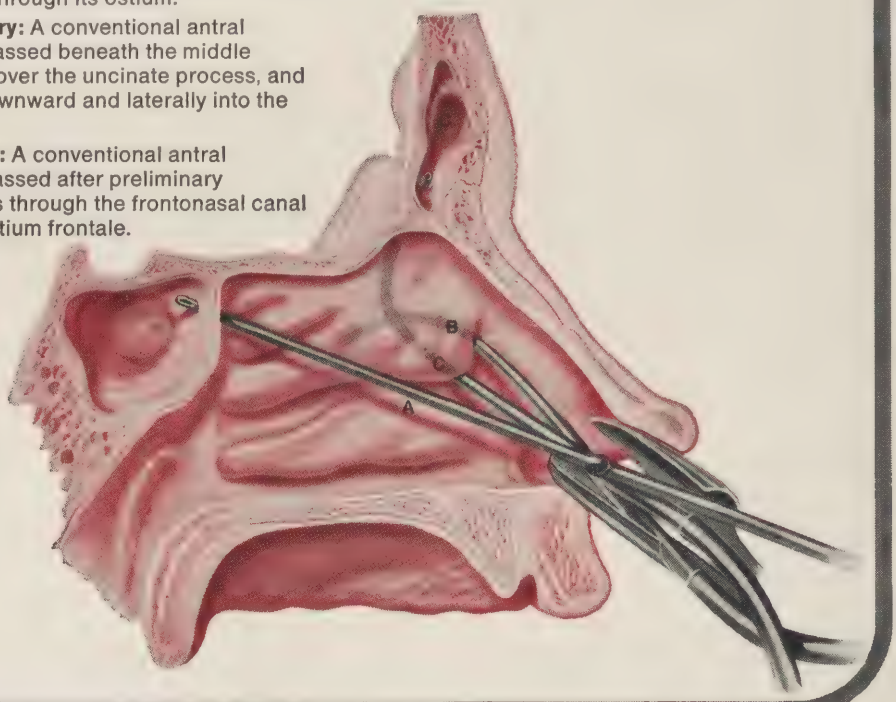
INDEX MEDICUS

A rhinologic approach to the sinuses
Sagittal anatomical section of nasal cavity showing approach for probing or irrigation by cannulas.

A—Sphenoid: A sphenoid cannula (under 13.5 cm.) passed around the middle and superior turbinates to the anterior wall of the sinus through its ostium.

B—Maxillary: A conventional antral cannula passed beneath the middle turbinate, over the uncinate process, and rotated downward and laterally into the ostium.

C—Frontal: A conventional antral cannula passed after preliminary maneuvers through the frontonasal canal into the ostium frontale.



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*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

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Neither illnesses nor accidents respect office hours. Many times a doctor's plans must be cancelled or his sleep interrupted by an emergency call. Doctors seem to take these into their stride, knowing that when the call comes the patient must be seen regardless of the time of day or night. The patient doesn't know in advance when he may need the services of his doctor or hospital care, so financial preparedness for unexpected illnesses or accidents is a sound practice every patient should employ. More doctors than ever counsel their patients in Blue Shield pre-payment medical programs because they realize that Blue Shield offers the most complete protection against unexpected financial emergencies.



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NOVEMBER, 1964 — VOL. 60, NO. 11

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Contributions of Original Articles

Length—Short articles of about 2,500 words (about 8 typewritten pages, double spaced) are preferred. Longer articles ordinarily will defer to the shorter ones in schedule of publication.

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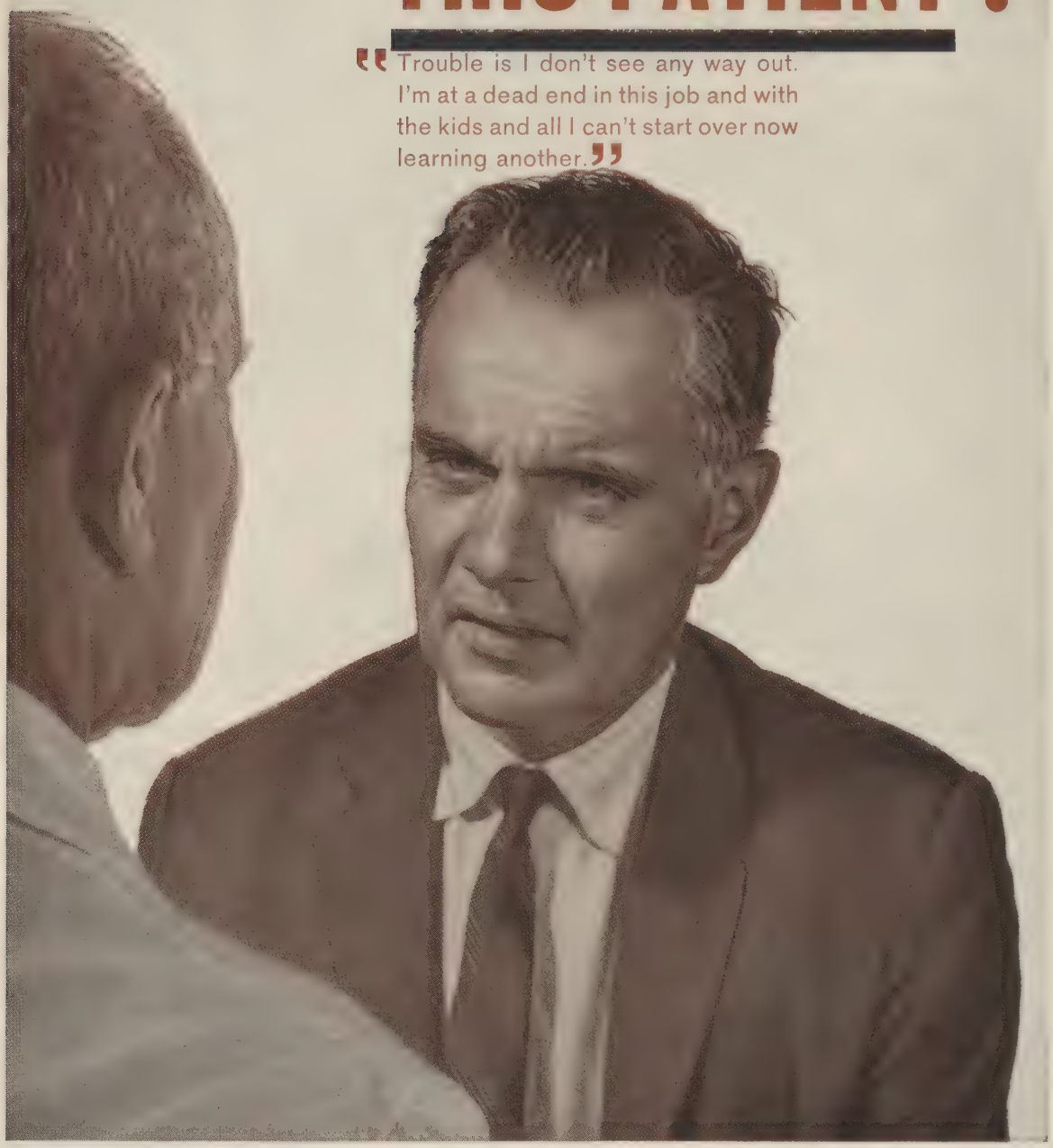
Illustrations—Ordinarily publication of 4 small illustrations or the equivalent accompanying an article will be paid for by The Journal. Any number beyond this must be paid for by the author except under unusual conditions. Illustrations should be sent as glossy prints or graphs in black ink with lettering large enough to show after reduction.

References—Should conform to the following order: surname and initials of author, title of article in small letters, name of periodical, with volume, page, month, day of the month if weekly, and year—e.g.: Lee, G. S.: The heart rhythm following therapy with digitalis, Arch Int Med 44:554, Dec. 1942. They should be listed numerically in order of appearance in the text. Standard abbreviations for journals should be used. Note that periods are not used with these abbreviations as indicated by the Index Medicus. Other abbreviations should also be standard—e. g. mg, ml, Gm.

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Indications: Depression, both acute (reactive) and chronic, especially when the depression is accompanied by anxiety, insomnia, and related symptoms. **Contraindications:** Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. **Precautions:** Should administration of meprobamate cause drowsiness or visual disturbances, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Prescribe cautiously and in small quantities to patients with suicidal tendencies. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal **Side effects:** Side effects associated with 'Deprol' have consisted primarily of drowsiness and occasional dizziness, and infrequent skin rash and nausea. *Benactyzine hydrochloride* – Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

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Typical situations in which 'Deprol' is indicated:

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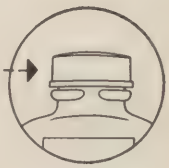
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Before prescribing, see SK&F Product Prescribing Information.

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1. Dorfman, W., and Johnson, D.: *Overweight Is Curable*, New York, The Macmillan Company, 1948, p. 16.

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Each 5 cc. (1 tsp.) contains:

Glyceryl guaiacolate	100 mg.

Alcohol 3.5 per cent

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Robitussin with antihistamine and codeine

Each 5 cc. (1 tsp.) contains:

Glyceryl guaiacolate	100 mg.
Pheniramine maleate	7.5 mg.
Codeine phosphate	10.0 mg.

(Warning: may be habit forming)

Alcohol 3.5 per cent

Robitussin is indicated in coughs associated with head and chest colds, bronchitis, laryngitis, tracheitis, pharyngitis, pertussis, "flu," "grippe," measles, chronic paranasal sinusitis, pulmonary tuberculosis, or smoking. Robitussin A-C is especially indicated for allergic, harsh or unresponsive coughs.

dosage: ADULTS—1 tsp. every 3 to 4 hours. CHILDREN—½ tsp. every 3 to 4 hours.

side effects: No serious side effects from glyceryl guaiacolate have ever been reported. Nausea, G-I upset, and drowsiness may be encountered rarely with Robitussin A-C.

precautions: There are no contraindications for Robitussin. Robitussin A-C is contraindicated in patients hypersensitive to antihistamines or codeine.

DIMETANE® EXPECTORANT

antihistaminic / antitussive

Each 5 cc. (1 tsp.) contains:

Dimetane® (brompheniramine maleate)	2 mg.
Phenylephrine hydrochloride	5 mg.
Phenylpropanolamine hydrochloride	5 mg.
Glyceryl guaiacolate	100 mg.

Alcohol 3.5 per cent in a palatable, aromatic base.

DIMETANE® EXPECTORANT-DC

(exempt narcotic)

antihistaminic / antitussive / suppressant

Codeine phosphate	10 mg.

(Warning: may be habit forming)

Dimetane® (brompheniramine maleate)	2 mg.
Phenylephrine hydrochloride	5 mg.
Phenylpropanolamine hydrochloride	5 mg.
Glyceryl guaiacolate	100 mg.

Alcohol 3.5 per cent in a palatable, aromatic base.

Indicated for relief of cough and allergic states in which an expectorant action is useful. Dimetane Expectorant-DC is indicated when the cough suppressant action of codeine is desired.

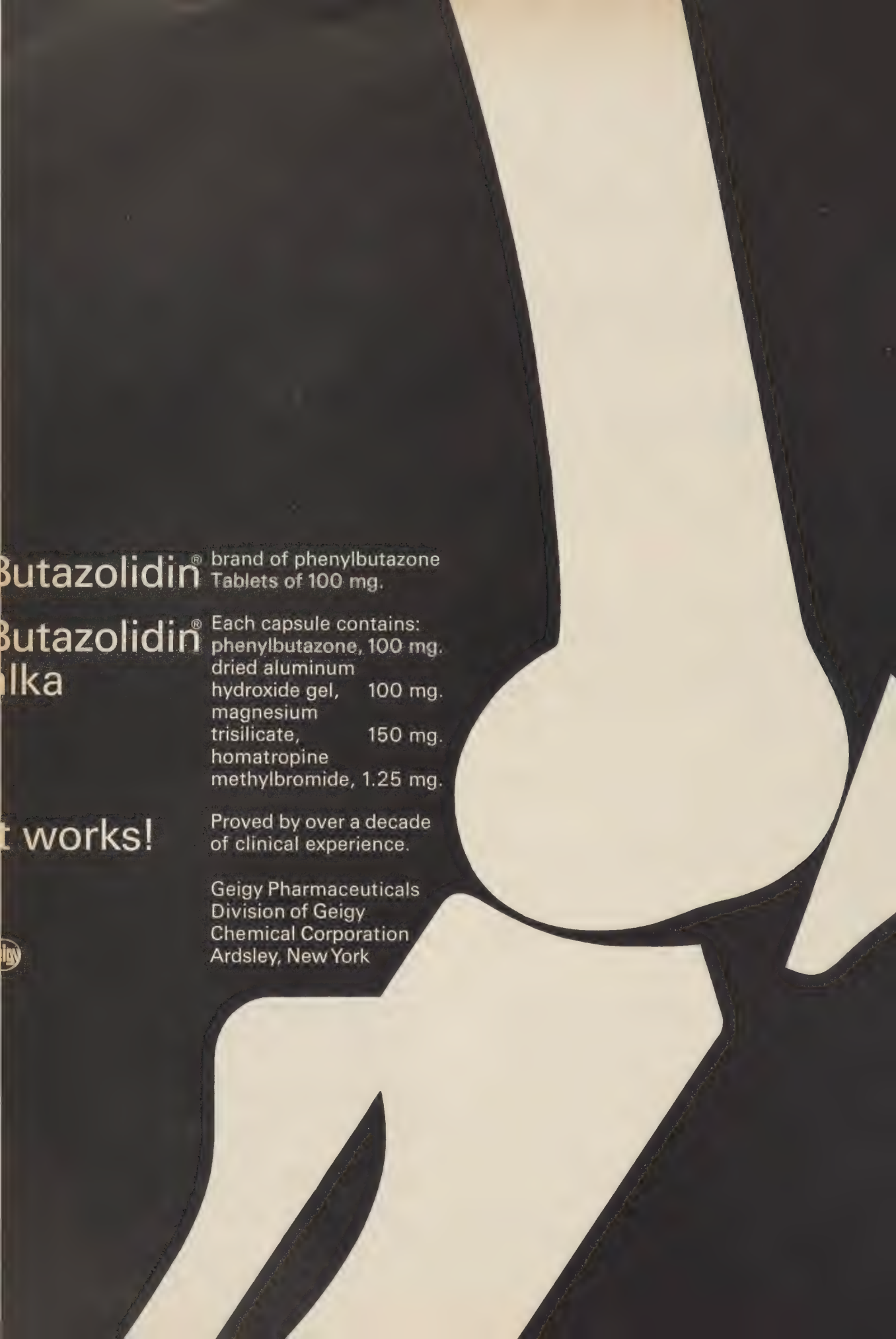
dosage: ADULTS—1 to 2 tsp. q.i.d., as necessary. CHILDREN—½ to 1 tsp., t.i.d. or q.i.d.

side effects: Overdosage may result in mild drowsiness or excitement, but within the therapeutic range neither is likely.

Precautions: Administer with caution to patients with cardiac or peripheral vascular diseases and hypertension.

contraindications: Hypersensitivity to antihistamines or codeine. Not recommended for use during pregnancy.

references:* Boyd, E. M., and Ronan, A. K.: Am. J. Physiol., 135:383, 1942.


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...is just for the sneeze

but for symptomatic relief of the common cold...

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TABLETS

Each layered tablet contains:

'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Phenacetin	150 mg.
Aspirin	200 mg.
Caffeine	30 mg.

To relieve the aches, pains, fever and respiratory congestion of the common cold, flu or grippe with one product ...specify 'Emprazil'.

Caution: While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed.

Supplied: Bottles of 100 and 1000.

Also available with codeine—on prescription only—as **'EMPRAZIL-C'® tablets**

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Regardless of the etiology of muscle sprain or strain, 'SOMA' COMPOUND helps relieve pain and relax muscle. Patient comfort can be increased and recovery time shortened.

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carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg.

rational combination therapy for sprains and strains: relaxes muscle, relieves pain. Also available with ¼ gr. codeine as 'SOMA' COMPOUND with CODEINE: carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., codeine phosphate 16 mg. (Warning: may be habit-forming.)

BRIEF SUMMARY

'SOMA' COMPOUND; 'SOMA' COMPOUND plus CODEINE: carisoprodol, acetophenetidin, caffeine, codeine phosphate. *Warning: Codeine may be habit-forming.* **Indications:** 'Soma' Compound and 'Soma' Compound with Codeine are indicated for relief of pain and stiffness in traumatic, rheumatic and other similar conditions. **Contraindications:** Allergic or idiosyncratic reactions to carisoprodol or codeine. **Precautions:** *Acetophenetidin*—May damage the kidneys when used in large amounts or for long periods. *Codeine*—Should be used with caution in addiction-prone individuals. *Carisoprodol*—Like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate. **Side effects:** *Codeine*—Nausea, vomiting, constipation, and miosis. *Carisoprodol*—The only side effect reported with any frequency is drowsiness, usually on higher than recommended doses. One instance each of pancytopenia and leukopenia occurring when carisoprodol was administered with other drugs has been reported as has an instance of fixed drug eruption with carisoprodol and subsequent cross-reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. Other rarely observed reactions have included dizziness, ataxia, agitation, increase in eosinophil count, and gastrointestinal symptoms. Massive overdosage may produce coma and/or mild shock and respiratory depression. **Dosage:** 'Soma' Compound and 'Soma' Compound with Codeine, one or two tablets three times daily and at bedtime. **Supplied:** 'Soma' Compound, orange tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., and caffeine 32 mg. 'Soma' Compound with Codeine, white, lozenge-shaped tablets, each containing carisoprodol 200 mg., acetophenetidin 160 mg., caffeine 32 mg., and codeine phosphate 16 mg. Narcotic order form required. *Before prescribing, consult package circular.*

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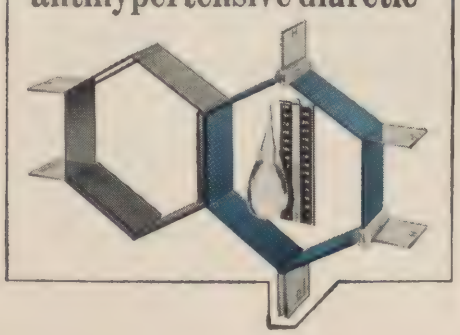
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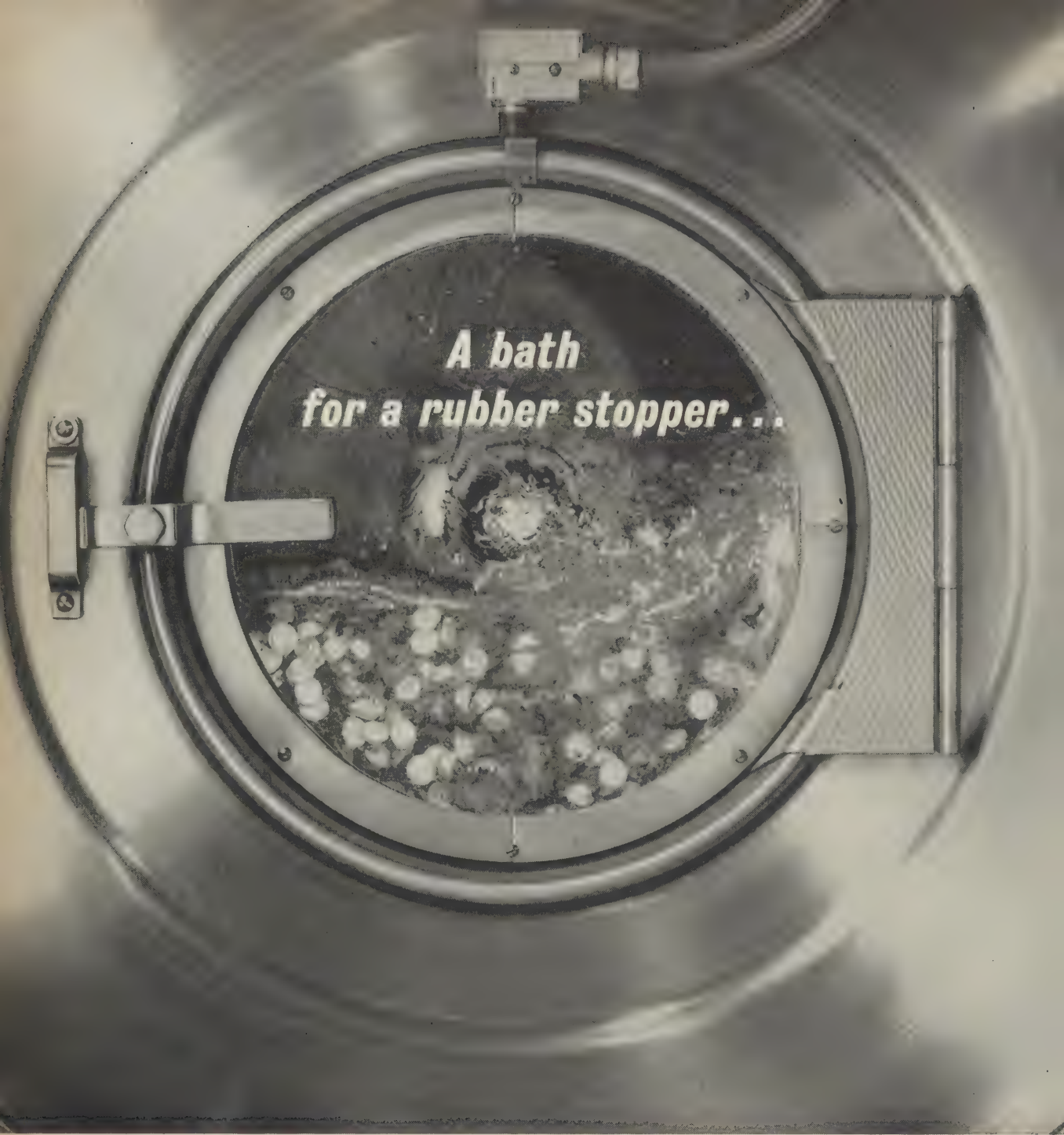
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The Journal
of the
South Carolina Medical Association

VOLUME 60 November, 1964 NUMBER 11

CHANGING CONCEPTS IN THE HYPERTENSIVE RENAL DISEASES

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The voluminous literature of the past 10 years concerning the hypertensive diseases attests to their frequency of occurrence and problematic nature. Although much emphasis has been placed on aldosteronism and renal artery abnormalities, the great unanswered problems are in the field of so-called "essential hypertension."

When one attempts to answer the question, "What is essential hypertension?" the problems become obvious. No two investigators agree on its nature or cause. The British have placed great emphasis on hypertension as an inherited characteristic. Robert Platt[1] has considered it a clearly genetic trait, probably arising from a single gene. Sir George Pickering,[2] on the other hand, was unable to support this concept in his study of the subject, although he concluded that it might be inherited as a polygenetic characteristic. He suggested a quantitative rather than qualitative difference—*i.e.*, if blood pressures were treated by the same statistical analysis as height or body weight, the old familiar bell-shaped curve would be seen. Some people tend to have higher blood pressures just as they may tend to be fatter on a genetic basis, but added environmental factors contribute. Hypertension, as obesity, contributes to vascular disease, so the results are difficult to separate from the causes.

In this country, more emphasis has been placed on other factors. Dahl[3] and others have pointed out the linear association of blood pressure elevations with salt in the diet and feel that excess sodium ingestion or abnormal regulation of sodium balance could be responsible. Grollman and Muirhead[4] have demonstrated the anti-hypertensive effect of normal kidney and relate the occurrence of hypertensive disease to loss of this protection. Goldblatt and others[5] have emphasized the renin mechanism and occult renal ischemia as a cause. Genest[6] has demonstrated increased aldosterone excretion in hypertensive patients, but it is uncertain whether this is a primary abnormality or the result of minimal increases in angiotensin secretion. Other investigators have demonstrated altered relationships between blood volume, vascular tone and myocardial contractility,[7] delayed inactivation of angiotensin,[8] increased reactivity to norepinephrine or angiotensin,[9] and so on.

Presented at the meeting of the Charleston County Medical Society May 12, 1964.

Page [10] has tried to relate these many phenomena in his so-called "Mosaic Theory," which includes elements of many other demonstrated abnormalities.

Since that time, however, new evidence has been presented which changes considerably the overall approach to the hypertensive diseases. In a well studied British series of 120 cases of hypertension,[11] an acceptable cause was found in 64% of the cases. This included anomalous renal development, pyelonephritis, glomerulonephritis, renal artery disease, endocrinopathies, and so forth. Less than 6% were surgically correctable causes. In the 44% classified as "no cause found," 50% had renal arterial anomalies, compared to 11% in the non-hypertensive population. Although considerable controversy has arisen about this last point, and with the recognition that this was probably an all white population, the fact still remains that a satisfactory cause for the hypertension was found in the majority of cases. A recent report in this country draws similar conclusions. In the series reported by Roland *et al.*,[12] an unsuspected incidence of 20% glomerulonephritis and 19% pyelonephritis was found. In patients who were less than 30 years of age when hypertension was discovered, 65% had either glomerulonephritis or pyelonephritis. Of the overall series, only 11% had a normal kidney biopsy, with 44% showing vascular changes diagnosed as nephrosclerosis. Only 2 out of 13 cases of pyelonephritis had positive cultures, but most cases of parenchymal renal disease did have significant proteinuria. These facts point out several aspects of these two diseases which have become apparent as the result of biopsy studies.

Brod *et al*,[13] have pointed out that only 45% of patients found to have pyelonephritis ever have frequency or dysuria. Bacteriuria is present in 81%, but often requires multiple cultures for demonstration. Proteinuria, if present, is characteristically of low grade—*i.e.*, less than 1 gram/day. Pyuria has often been used as a guide but may not correlate well with bacteriuria and is often confused with the presence of renal tubular epithelial cells, the hallmark of glomerulonephritis.

The long-held opinion that 85% or more of acute glomerulonephritis heals completely has also been challenged recently. Kushner[14] has found that as many as 50% of the adults who develop acute nephritis go on to chronic disease. Recent attention has also been called to the occurrence of acute glomerulonephritis without proteinuria[15] and in the elderly.[16] Certainly this disease has been shown to be more common than previously recognized, and may be entirely missed. Heavy proteinuria in a hypertensive patient, however, is strongly suggestive of glomerulonephritis.

In view of these recent developments, where do we stand in regard to the nature and treatment of so-called "essential hypertension" today?

First, the aging of the population as a whole has necessitated the re-definition of a "significantly elevated" blood pressure. Master and Lasser[17] have studied this problem thoroughly and indicate that at age 65 and above, the best dividing line that can be drawn between the "normal" group and the "hypertensive heart disease" group is 170/100 mm Hg for males and 180/103 for females. This is considerably higher than the established limits of 140/90, but is a necessary adjustment in thinking, considering the tendency to physiologically higher pressures in the aged patient. A great deal of confusion can be avoided by limiting the discussion to such established levels of hypertension, excluding those with systolic elevation alone.

Next we must consider that most of the previously reported work has been on heterogeneous groups with multiple underlying and unrecognized diseases. Therefore, we can say that the tendency to excessive natruresis after salt loads, increased responsiveness to norepinephrine, increased aldosterone secretion, and many other reported abnormalities in "essential hypertension" may be characteristic of patients with elevated blood pressure, but are not necessarily causally related. In other words, we need to clearly define the

altered electrolyte, endocrine and cardiovascular alterations *due to* increased pressure as well as to the vascular consequences of increased blood pressure, without attributing to them any etiologic or diagnostic significance.

Friedman[18] has suggested that the final common pathway for hypertensive processes is the cationic gradient of the smooth muscle cell of the arteriolar wall. In other words, the relationship of sodium ion in the perfusing fluid to that inside the muscle cell may determine the state of tonus, or reactivity, of the muscle cell (see Figure 1). Substances associated with a pressure rise—epinephrine, norepinephrine, vasopressin, angiotensin, and aldosterone—*all* produce an increase of intracellular sodium relative to extracellular sodium. The work of Tobian[19] and others demonstrating increased cation content in blood vessels from hypertensive animals would tend to confirm this concept. However, these changes could occur in any hypertensive process so cannot be considered to be etiologic. The role of potassium in muscle tone and the interrelationship of sodium to potassium may be even more important, but are not at all understood. At this point we can only speculate that the relative concentrations of sodium and potassium in the muscle cell and their relationship to that of the perfusing fluid may be of great significance in understanding the hypertensive process and deserve further study.

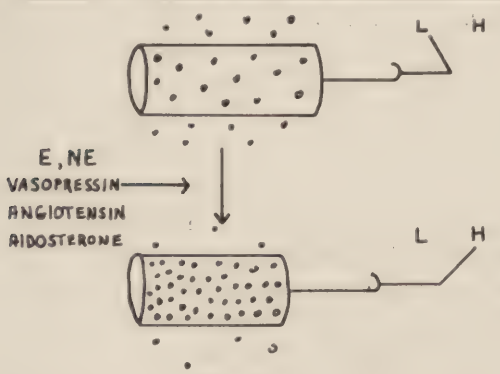


Figure 1.

Schematic representation of the altered cation (⁺) relationships in the smooth muscle cell associated with hypertensive processes.

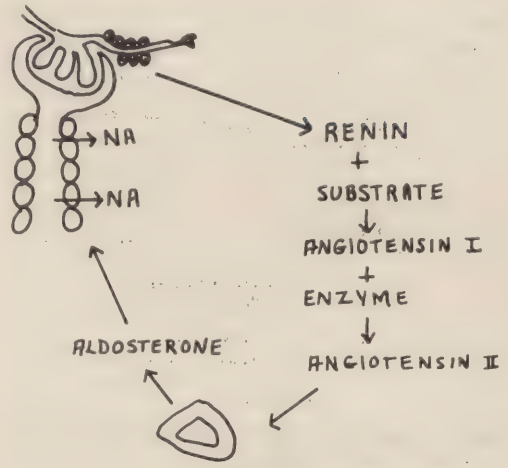


Figure 2.

Diagrammatic representation of the glomerulus with its juxta-glomerular apparatus and its relationship to the renin-aldosterone system.

It is also quite clear that hypertension of any cause leads eventually to alteration in small blood vessels and that this in turn may lead to altered renal hemodynamics. Hypertensives of even mild degree manifest decreasing renal blood flow over the years as nephrosclerosis progresses. Glomerular filtration rate is well maintained until late, with increasing filtration fraction. This is a circumstance known to favor reabsorption of sodium. Changes in the intra-renal vessels also occur in diabetes, gout, hypercholesterolemia, and perhaps on an isolated genetic basis. The decreased pulsatile perfusion of the juxta-glomerular apparatus which results from proximal arterial changes produces increased renin production[19] (see Figure 2). Renin plus renin substrate and activating enzyme of plasma results in angiotensin II production. This is the most active pressor substance known, and in turn stimulates aldosterone production. Aldosterone causes the kidney to reabsorb more sodium, thereby perpetuating the hypertension. Thus the presence of any type of glomerular or renal arterial disease favors the abnormal retention of sodium. In fact, our best information to date would suggest that accelerated or malignant hypertension is nothing more than the expected consequence of prolonged hypertension of any etiology which has resulted in alterations

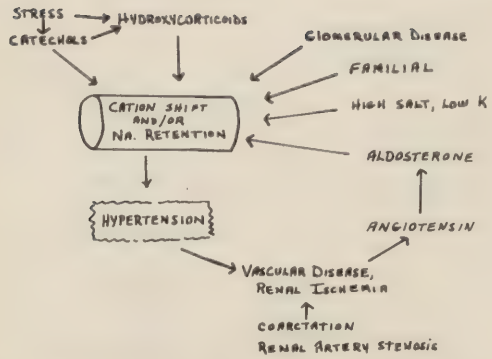


Figure 3.

Summary of proposed interrelationships in the hypertensive renal diseases.

in the renal vascular bed, leading to ischemia and excessive renin release.

We can summarize the interrelationships discussed above in the following diagram (Figure 3). Many things, such as stress leading to catechol amine and cortisol excretion, glomerular disease, secreting tumors, or just high sodium intake, all favor the retention of sodium or an altered cation (Na + K) gradient in the smooth muscle of arteries. A similar observation in familial hypertension suggests an inherited hormonal or renal mechanism, which is certainly not clear, but leads to the same end result. Altered renal perfusion, due to obstructed blood flow at any level from the aorta to the arteriole, leads to angiotensin release. This produces alterations in the cation gradient as well as sodium retention due to aldosterone excess. In short, either the cation gradient and/or sodium retention or both become the common denominator in many hypertensive processes.

Concerning theories about hypertension, Irvin Page[10] has said: "I care little whether the skeleton I have proposed is the one to be clothed. Since most people have skeletons in their closets and since most skeletons are fundamentally alike, get your own and see how useful it can be!" Thus, the formulation proposed here is only another skeleton in the closet but suggests useful measures in the treatment of hypertension.

First, all of the proposed mechanisms involve sodium metabolism. Clinically this has proved to be most useful. Much hypertensive disease can be controlled by the simple expedient of asking the patient to refrain from adding salt to the diet and from eating salty foods, plus the addition of moderate dosages of thiazide diuretics. This is by far the most successful form of therapy and does not produce unpleasant side effects. There is little advantage to high dose therapy which increases potassium wastage. If the diet is adequate in potassium, supplements are not needed except in digitalized patients or in patients with accelerated or malignant disease where secondary aldosteronism leads to excessive urinary loss.

Secondly, the deranged sodium balance itself predisposes to increased vascular reactivity and blood pressure lability, again emphasizing the utility of correcting physiologically deranged sodium metabolism rather than resorting to excessive sedation. No one would deny the emotional aggravation of hypertension however, and the rauwolfia drugs have proved their usefulness in selected patients.

Thirdly, drugs which produce a fall in renal blood flow are a two-edged sword and may stimulate further release of pressor substances as well as decompensate an already compromised kidney. Therefore hydralazine and a-methyl dopa, which do not decrease renal blood flow, are preferable to the ganglionic blocking drugs where possible, and are particularly useful in renal failure.

Fourthly, blood pressure must be completely and continuously controlled at *normal levels* (as defined above) wherever possible to prevent the progression of nephrosclerosis and further augmentation of the hypertensive process. When patients are seen early in their course, this is not usually difficult. However, when seen after advanced vascular and cardiac damage has occurred, the wisdom of rigidly controlling blood pressure can be doubted. In such patients hypertension is high and fixed, requiring blocking drugs such as

guanethidine for control. This invariably results in weakness, dizziness on assuming the erect posture, disturbing visual difficulties, and other complaints. However, if frequent checking of the blood pressure in the *standing posture* does not reveal low levels, and angina is not induced, the pressure should be carefully and gradually lowered to normal levels despite protestations from the patient. After approximately 6 months, readjustment occurs and symptoms disappear. Drug dosages may be reduced after a period of good control. This suggests again that hypertension of any etiology, once established is self perpetuating, although the process has now been shown to be effectively interrupted with good drug therapy. Irvin Page[20] comments in this regard:

"The partial conquering of hypertension has come about so slowly as to be almost imperceptible. The result has been that many physicians are not aware of it. Most patients have not been prepared psychologically for the long and, at times, arduous demands of adequate treatment, and consequently, I am sorry to say, most of them are not getting it."

To conclude, we have tried to establish certain facts concerning hypertensive diseases:

1) Much too much emphasis has been placed on the etiology of "essential hypertension." Recent information would suggest that this entity is a disappearing species and was never much more than a wastebasket for multiple undiagnosed renal, hormonal, or familial disorders, some of which we still do not understand. "Hypertension" is a sign of many diseases and not an established diagnosis.

2) Parenchymal renal diseases are often silent and by far the most likely cause of hypertensive disease, particularly in the patient under 30 years of age.

3) The diseases which produce hypertension result in abnormalities of salt balance and therefore can all be approached therapeutically through this common denominator.

4) Complete control of blood pressure, regardless of its cause, is essential in the prevention of other vascular changes and self perpetuating disease. It is particularly valuable to discover hypertension early in the patient's course and control it before irreparable damage is done.

5) All persons with elevated blood pressure deserve a leg blood pressure reading, urinalysis, several urine cultures, an intravenous urogram, serum electrolytes, and a post-prandial blood sugar. If no abnormalities are found medical therapy is indicated.

6) For the patient who is not controlled at *normal levels* on moderate salt restriction, a thiazide, reserpine, and apresoline or a-methyl dopa, additional evaluation is required if the patient is less than 50 years of age, has been hypertensive less than ten years, and has no other life-limiting cardiovascular complications or coincidental illnesses. Acute onset malignant or accelerated hypertension deserves immediate full evaluation at any age.

7) To achieve the greatest number of positive diagnoses with the fewest possible tests, the further evaluation of a patient should include:

(a) renal biopsy
(b) aortogram
(c) regitine test
(d) steroid excretion studies, catechol amines, etc.

It should be pointed out that a renal biopsy on a hypertensive patient is more likely to produce complications than in the normal population. Therefore, it should be done with due consideration for coagulation factors and under good sedation. Blood pressure should be well controlled during and after the procedure, and biopsy as well as aortography is contra-indicated in patients with established azotemia of greater than 60 mg/100 ml blood urea nitrogen.

8) A great deal has been said and written about renal arterial disease recently, but this probably represents less than 5% of the established causes of hypertension. Patients with this disease do well on drug therapy for long periods. Therefore, the above criteria

are adequate as indications for aortography with an additional stipulation. Any patient under 30 with recent onset hypertension of even a moderate degree has a much better chance of having a renal cause than the older patient. These patients when possible should all have further evaluation, including a biopsy. The I^{131} hippuran scan, mercury^{203} scan, the multiple split function tests, and many other screening tests recently recommended all have limited usefulness and cannot be wholeheartedly recommended. If the disease warrants, aortography should be done as a primary step. However, in difficult cases, split function tests may also be necessary to differentiate the significance of possible abnormalities in the renal vessels. After two years of follow-up much of the early enthusiasm for renal artery abnormalities has waned, and the role of this disease in the eventual story of the hypertensive disease states remains unwritten.

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TREATMENT OF CUTANEOUS FUNGOUS INFECTION WITH TOLNAFTATE

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Charleston, S. C.

It was hoped that griseofulvin would be the final answer to the problem of fungous infections of the skin. As with many other new drugs, some disadvantages came to light after extensive use in clinical practice. Some patients developed allergic reactions, many suffered so much nausea and headache that they had to discontinue the medication, and in a few cases, the drug was not effective.

In the past topical methods of treating fungous infections were mainly dependent on the peeling properties of salicylic acid, fortified by fatty acids and a few mildly fungicidal drugs. These were applied in tinctures, paints, creams, or ointments with varying success but with notably poor results in the treatment of the scalloped persistent ringworm (Trichophyton rubrum) of the smooth skin of the body.

Months and months of treatment were sometimes futile in the face of a probable immunological defect in the patient's skin.

Japanese physicians found dimethylthiocarbanilate very effective for local treatment of fungous infections. An American pharmaceutical firm prepared this tolnaftate (generic name) as Tinactin 1% in liquid and cream. Nineteen investigators in this country found it promising. For the past ten months I have studied it in the treatment of 176 consecutive cases of clinical fungous infection. The drug, so far, has been non-irritating, non-sensitizing, and can be used with impunity on even séverely irritated skin. On raw areas there is occasionally a mild stinging (this sting can also be caused by plain water). All patch tests for sensitivity have been negative even on previously abraded skin.

In the cases studied, scrapings of the skin lesions were softened with potassium hydroxide and examined with a microscope immediately. Cultures on Sabouraud's medium were performed in every case and both scrapings and cultures were repeated at weekly intervals when possible. Notation of clinical improvement was made weekly. The results were summarized in Table 1.

Twelve cases were studied by paired comparisons, double blind. Where a fungous infection was found and proved, in all of these cases the response was definite to the use of tolnaftate and there was no response in this short series to the control liquid and cream. Patch tests were made in practically all cases and there were no cases of irritation. Five patients with very raw skin complained of stinging. Trial of plain water in these cases also caused stinging and the reaction was felt to be non-specific and due only to the denuded skin.

A good many of the cases in which fungi were found on initial microscopic examination later showed monilial infection on culturing. It was not always possible to identify a monilial infection with the microscope at the initial examination. However, when clusters of spores were found along with fine hyphae, the initial diagnosis could be made.

The response of the various fungous infections was indeed gratifying but it was noted that tolnaftate had no inhibiting effect on monilial or yeast infections. Often a yeast infection was cleared up only to find an underlying mycotic infection remaining. I was surprised not only by the relatively large number of monilial infections but also by the

TREATMENT OF ONE HUNDRED SEVENTY SIX CASES FUNGOUS INFECTION

Site	T. rubrum	Tinea versicolor	M. audouini	Moniliasis	Bacterial	Miscel. fungi
Scalp	0	1	24	0	4	3
Body	14	24	2	6	11	22
Feet	8	0	0	6	1	25
Hands	2	0	0	2	2	8
Nails	1	0	0	1	0	8
RESPONSE TO THERAPY						
Good	23	23	6	0	0	55
Fair	0	1	0	0	1	0
Poor	0	0	8	15	10	4
Lost to followup	2	1	12	0	7	7

number of cases in which the monilial and mycotic infections alternated with each other—those cases of infection where there is either alternation between a predominant fungous infection, a monilial infection, or a bacterial infection. This alternation appears in those cases where, in married couples, one clears under treatment only to be reinfected by the marital partner and vice versa. It is always wise to check both husband and wife when crural and genital areas are involved in the eruption.

Fungous infections of the hair and scalp did not respond well. After three months of persistent treatment, many of the patients with scalp infection were still fluorescent and cultures remained positive. However, six of fourteen cases did respond quite well to topical treatment only. There were several instances of ringworm of the scalp which were due to other organisms besides M. audouini and these did respond well.

On the body, the response of Trichophyton rubrum and purpureum infections was spectacular. It was truly amazing to watch these infections practically clear up in a week or so in direct comparison to months and months of other topical therapy.

Recurrence has not been the case during the ten months of observation but should be considered likely in that the patients with this infection exhibit a probable immunological defect and recurrence occurs after griseofulvin therapy as well. But this topical therapy works much faster than griseofulvin.

Foot and hand infection also responded well to tolnaftate. In all instances response was much faster than that to griseofulvin and more complete. In this series the high incidence of monilial infection of the feet was surprising.

Fungous infections of the nails did not respond particularly well but persistent scraping off of infected nail tissue and the use of tolnaftate usually produced negative cultures and clinical clearing. Of eleven cases of nail change, there was one case of monilial infection, one of bacterial infection, and there were nine cases of definite fungous infection. Four cases cleared with tolnaftate treatment.

Tinea versicolor, due mainly to Malassezia furfur, was surprisingly common in this series. I found Tinactin excellent but slow. The treatment had to be continued for four weeks in most cases but after this time no fungi could be found on scrapings and I feel that this is the best remedy for this condition available at the present time. It was noticeable that any small patches missed by the patient showed no improvement. Careful examination with the black light was necessary before a patient could be discharged and close supervision during treatment was necessary.

If an eruption resembles fungous infection, the usual procedure is to give griseofulvin for a week or two as a clinical trial. When this fails, a steroid cream is given on the assumption that the eruption is an allergic inflammation of the skin.

Recommended procedure is first to scrape and examine the scales from the eruption microscopically for fungi. A culture should be taken at the first visit. Small culture bottles of Sabouraud's medium are available through the surgical supply houses at small cost and it takes only a moment to plant some scale or skin on the surface. No incubator is necessary; just watch the bottle of culture, looking on the third day for small white moist colonies of monilia and during a 14 day period for slowly appearing colonies of fungi. The rubrum and purpureum organisms slowly develop a rich deep purple base which is characteristic.

If the condition does not respond to griseofulvin (I now definitely prefer the topical treatment with tolnaftate which is quicker and safer), especially if the eruption is moist and intertriginous in groins, etc., then a monilial infection should be suspected and some form of nystatin should be used topically.

One must not assume that adequate intake of griseofulvin rules out fungous infection. Fungi can often be cultured from the skin after months and even a year of griseofulvin medication. If there is no response, suspect first that a monilial infection has been freed from mycotic inhibition and, if there is no response to nystatin or amphotericin B lotion, then assume that there is a resistant fungous infection or a mixed eczematous inflammation not responsive to either type of medication. In this dilemma, repeated microscopic examination of the skin and repeated cultures lead the way to choice of the proper medication.

Summary

Tolnaftate has proven itself as an excellent fungicide, acting as a chemical and not by peeling or exfoliation. It works best in the treatment of Trichophyton rubrum and purpureum, excellent in treatment of tinea versicolor, and in most of the other superficial fungous infections.

It is relatively poor in infections of the nails, requiring persistent application for a long time and griseofulvin, if tolerated, is preferred, but combined treatment with both tolnaftate and griseofulvin may be best of all.

It is only partially successful on scalp infections and may be combined with a primary reliance on griseofulvin.

On feet and body, it is the treatment of choice, being much faster and more effective than griseofulvin.

Also in cases of griseofulvin intolerance, tolnaftate is an excellent addition to the fungicidal armamentarium.

The tolnaftate used in this study was supplied as Tinactin 1% liquid and cream by John A. Leer, Jr., M. D., Schering Corporation, Bloomfield, N. J.

POISON CONTROL IS POISON PREVENTION

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Some 500,000 accidental ingestions of potentially toxic substances occur among young children in the United States each year. Carelessness or lack of awareness on the part of adults has placed within the reach of children common household products and medicines which can cause serious injury or death. There are treatment procedures for such accidents, but, more important, basic preventive measures are needed.

With this necessity in view, the Poison Control Branch of the Public Health Service's Division of Accident Prevention, in cooperation with the South Carolina State Board of Health and the Charleston County Health Department, in 1961 inaugurated a pilot project to investigate techniques geared to the prevention of poisoning accidents among children. The years 1957-1961 were established as the baseline period to which subsequent records would be compared.

The difficulty of getting an accurate figure on the total number of ingestions made this an unreliable index of the extent of the poisoning problem. Therefore, the decision was made to use as a basis for comparative reports, the records of patients under five years of age hospitalized one or more days for acute accidental poisoning (excluding lead poisoning). Four participating hospitals produced 246 cases.[1, 2]

One year later, a preliminary analysis of the reports indicated a significant decline in hospitalized cases from 90 (1960-61 average) to 66 (27 per cent). Table 1 shows the pattern of these changes.[1]

Several factors were considered in selecting the Charleston area as the project site:

The professional health and medical groups were receptive to the program;

The area had a population of approximately 200,000 — large enough to provide adequate case data — small enough to provide a controlled study with a minimal number of professional personnel;

Hospital records were available to establish baseline data;

Rapport existed between the health agencies and communications media;

An active poison control center could provide cases for epidemiologic follow-up and provide consultation to project personnel.

An educational campaign aimed at adults and others responsible for the care of children was planned. Since this was the first effort on the part of the Public Health Service to concentrate on the prevention of poisoning accidents as a specific project, there was complete flexibility to explore and apply many varying ideas.

The project was under the general direction of the County Health Officer with technical guidance from the Department of Pediatrics of the Medical College of South Carolina. As a health department project, it was to be incorporated into the continuing programs of that agency.

Although the public health nurses had been discussing poison prevention measures with their assigned cases, the intensive nature of the project involved supplementing the health department staff with specialized personnel. These included a public health nurse, a secretary and someone skilled in techniques of community organization, public relations and in the effective use of the media of mass communications. The last prepared materials, assisted in the preparation of speakers' guidelines, oriented personnel, and helped to coordinate the poison prevention activities of

the health department, the poison control center and the Department of Pediatrics of the Medical College Hospital. He sustained liaison between the local health department, the State Health Department and the Public Health Service.

The nurse coordinated follow-up procedures of reported ingestions with the health department's public health nurses, acted as a clearinghouse for case reports reaching the health department from the poison control center, pin-pointed cases and areas of occurrence to facilitate program planning, and assisted in organizing and conducting community programs.

The secretary, in addition to her clerical duties, conferred with community and civic organizations to arrange for poison prevention activities, scheduled programs, and maintained a list of speakers available for such programs.

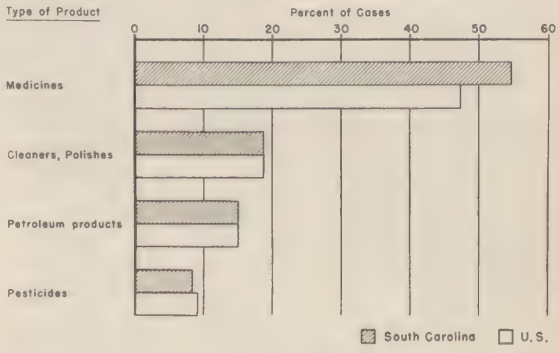
In the months before the program began officially, discussions were held with community leaders representing the county government, the State Extension Service, hospital administrators, college professors (with knowledge of the county's socio-economic structure), officials of the medical and nursing societies, representatives of the news media, public and parochial school administrators and presidents of civic and other community organizations.

"A Guide for Lecturers" was prepared. This paper contained basic facts, statistics and case histories. A Speakers' Bureau, consisting of volunteer physicians and nurses, was established. Participants were informed that as members of the bureau, their role would be to present programs to previously arranged meetings of local community groups. In months to come, members of the Charleston County Medical Auxiliary and representatives of two civic groups were to be added to the list of volunteer speakers. A major effort was devoted to programs among parent-teacher associations, church meetings and other organized groups.

Program Techniques

In addition, discussions were developed among residents in neighborhoods of high incidence.[3] The nurses posted multicolored pins (to indicate types of ingestion) on a detailed map of the county. Predominantly, these ingestions involved petroleum distillates (mainly kerosene), medicines (mainly aspirins), and lye and caustic materials (drain and bowl cleaners). The map was reviewed regularly to determine in which neighborhoods small discussion groups might best be initiated.

Figure 1 Hospitalized cases among children under 5 years of age By type of product ingested South Carolina and U.S., 1961



Kerosene ingestions, for example, were found to occur primarily in neighborhoods of relatively low socio-economic status. After a specific neighborhood was selected, the public health nurses arranged with one person within the neighborhood to take the responsibility for organizing a program, either in the home or some other suitable, convenient meeting place.

Attempts were made to hold attendance to no more than 12 women. Since these meetings were held in high-incidence areas, the group generally included women who had had experience with accidental ingestions in their homes, as noted earlier, and frequently they related their personal experience with the problem. The role of the official representatives was to stimulate discussion with a minimum of active participation on their part.

The technique of group discussions in the neighborhoods had drawbacks. In many areas, where these discussions were needed most, people were of limited means, had very small, inadequate homes. Mothers were reluctant to

TABLE 1.
HOSPITALIZED CASES AMONG CHILDREN UNDER 5 YEARS OF AGE
(BY SEMI-ANNUAL PERIOD OF ADMISSION
CHARLESTON, SOUTH CAROLINA, 1961-1962)

Period	Number of Cases		Per Cent Difference (1962/ 1960-1961) (Average)
	1962	1960-1961 (Average)	
Year	66	90	27
January-June	37	48	23
July-December	29	42	31

invite guests, particularly when these included agency personnel. Often, the nurses found that they had to make personal calls to recruit attendance at these discussions.

The staff has since held similar discussions among large groups of mothers at pre-natal and well-baby clinics. These clinics are conducted by the health department. Many of the patients at these clinics come from the high-incidence neighborhoods previously mentioned. As many as 60 or more women might be present. The poison prevention discussions are being held during the waiting period between registration and seeing the physician and are given by the Woman's Auxiliary to the Charleston County Medical Society, many of whose members are former teachers and nurses.

The auxiliary to the medical society takes a sincere interest in factors affecting community health. The poison prevention project lent itself well to their overall program. After an appropriate orientation, these women led and participated in clinic discussions, many creating their own visual aids.[4]

At the request of a group of kindergarten teachers, a teaching unit was developed on the supposition that children in this age group report rather completely to their parents on school events. The manual has proved so popular that it has been introduced on a statewide basis. Aid has been requested in the preparation of a similar manual for the primary grades.

Another manual containing educational material and suggested ideas for reaching the general public was prepared at the request of the South Carolina Federation of Colored Women's Clubs.

Bus cards emphasizing the need for poison-proofing the home were used in the public transportation system. Grocery stores were provided with flyers to be inserted in each customer's bag. The health department used a "slug" on its postage stamp machine with a poison prevention message on all outgoing correspondence.

A form letter was sent to each parent when the child—based on county health department records—reached 18 months. Parents were reminded about the hazard of accidental poisoning and its relationship to the growth and developmental stages of the child.[5] Another letter was sent to parents after a poisoning episode occurred. The letter suggests that this would be a good time to check the home, garage, etc., to make sure that all potentially poisonous materials are out of reach.

Poster contests have been conducted among the Boy Scouts and a high school art class and the entries used as exhibits in grocery stores, pharmacies, clinics, and military bases. A vocational drafting class provided a number of statistical posters.

Radio and television has been used extensively. Spot announcements have been used regularly as well as panel discussions, interviews and film showings. The newspapers have been generous in space allocation to plans for the project, human interest stories, and a featured weekly tabulation of the number and types of poisoning cases. Both the Navy and Air Force publications have given space to the problem also.

Since the leaking kerosene stove is both a fire and poisoning hazard, the Fire Chief cooperated and instructed his inspectors to be particularly alert to this hazard during home inspections. In 1962, more than 6,000 homes were checked, many of which were of the type most needing information and instruction on preventing poisoning accidents. A coloring book emphasizing fire and poison prevention has been designed and is currently being dis-

tributed by the inspectors on their visits to homes, schools, etc. To make the book fun for children and yet educate through pictures that pre-school children could understand, a caricature owl, "Prevention Pete," was used. "Prevention Pete" was designed so as to be used as the project emblem on educational materials developed in the future.

A bookmark has been designed for distribution at county and school libraries, and commercial book stores. Approximately 50,000 bookmarks, along with other literature, were distributed in five months. Another outlet was the County Fair, where a booth has been maintained and a poison prevention exhibit displayed.

During the summer months, the project shifted its major emphasis from the parents to the children, continuing attempts to test techniques of education and information via the youngsters. Many children of various ages (4-16 years) were reached through YWCA and YMCA day camps, Girl Scouts, Boy Scouts, church schools and community centers.

For one month, a poison prevention exhibit was displayed at the Charleston Museum. The exhibit included a section on poisonous plants and flowers found in the Carolina Low-country, prepared by members of the medical auxiliary; various containers exhibited by student nurses from which children in the county had taken poison, and a map showing what and where poisons were ingested. Approximately 330-400 persons visited the museum daily.

In the third week of March—each year, National Poison Prevention Week has provided an opportunity for increased emphasis. In fact, the week's activities provided a focal point for combining the efforts of civic clubs, the local pharmaceutical associations, wholesale drug companies and pharmacies, the medical and allied professions, military personnel, merchants and the communications media. This year (1964), as part of a statewide project, a questionnaire was sent to all elementary grade schools (Grades 1 through 6). The questionnaires on poison proofing the home were sent home to be answered and signed by the parents. "Prevention Pete" badges and certificates for classrooms were given to the first, second and third graders as an incentive for returning the questionnaires.

The purpose of a demonstration project is to test the impact, if any, on a local population of motivational methods and techniques designed to achieve a specific objective. In this case, the local project sought to achieve a reduction in the incidence of accidental poisoning.

As noted earlier, a 27 percent decline in hospitalized cases due to this cause has already been observed. In May 1962, the community was surveyed to evaluate the effectiveness of the operation in terms of the message being received by the population, the media by which this message was received, and the public reaction to the message, i.e., what did they do about it? Originally, the plan called for interviews with approximately 1700 families that had children under six years old. Problems involving recruitment of sufficient interviewers, most of whom were volunteers from several women's organizations, cut this realization by more than half. Considering that Charleston County encompasses some 945 square miles, the project was fortunate to have had the aid of women volunteers, especially the medical auxiliary, another example of the excellent community cooperation.

Because of the relatively small number interviewed, the projection of results to the entire population of Charleston could only be done cautiously. The sample itself was limited to households having one or more children under six years of age; there was a close resemblance to the Charleston population in terms of racial composition and economic level (based on the occupation of the head of household).[5]

Approximately 82 per cent of those interviewed had heard or seen something about the dangers of children accidentally eating

or swallowing medicines or household products. There was no significant difference in the proportion of positive responses by the different occupations or racial groups.

The two most common sources of information about the hazards of accidental poisoning were newspapers, 48 per cent, and television, 34 per cent. Interestingly enough, very few (7 per cent) indicated that such information had been received from physicians.

Many of the respondents indicated a change of methods of storage of hazardous substances, several as the result of direct exposure to a project activity. Of those who reported an accidental ingestion in their homes, over 70 per cent stated that the first action they took was to seek medical care, either through their physician or the emergency room, both actions having been recommended by the project.[6]

Summary

This educational project concerning the prevention of accidental poisoning among children has been going on for three years. The educational attempts are apparently producing results for there has been a 27 per cent decline in hospitalized cases. Various techniques used have been described. An initial survey gave an indication of methods by which the public was being reached.

The project is continuing for another year with the hope that further declines may be noted. While some of the techniques employed here may have to be modified in other areas, it is the ideas which are important. It is hoped, therefore, that from this local project's findings, other health agencies will be in a position to initiate or expand specific activities in poison prevention.

Acknowledgments

The authors wish to acknowledge with appreciation the contributions made in the preparation of this paper by Hilla Sheriff, M. D., S. C. State Board of Health and Mrs. Dorothy Neyman, U. S. Public Health Service.

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MEDICAL TELEVISION SCHEDULE

On the first Thursday and Friday of each month, **8:00-9:00 p. m.** the Division of Postgraduate Education of the Medical College of South Carolina, in collaboration with the ETV Network, produces medical television programs for the physicians of South Carolina.

December 3 and 4, 1964—TREATMENT OF CONGESTIVE HEART FAILURE
Guest—Dr. George Burch, Prof. of Medicine
Tulane Univ. Med. School

In addition to these South Carolina TV productions, programs from other centers will be shown on the **third Thursday** of each month, at 8:00 p. m.

December 17, 1964—Hyperthyroidism (N. Y. Acad. of Medicine)
Drs. Sidney Werner and Kenneth Sterling
Columbia Univ. College of Physicians and Surgeons

NOTE—All Thursday programs are carried on both the closed-circuit ETV Network **and** Channel 7 (Charleston), channel 29 (Greenville). Friday showings are on closed-circuit into the schools and hospitals only.

Supported by a grant from the Merck Sharp & Dohme Postgraduate Program.



President's Page

Consideration for the Patient's Finances.

While our primary consideration is for the health of the patient, at the same time it is well to remember that most patients worry over finances as well as their health. In fact, worry over finances may well be a factor in many illnesses. As an intern or resident one easily gets into the habit of ordering many costly laboratory procedures which might be in the interest of good and complete medical care, and which at the same time might not be really necessary in the care of the patient. When the cost of such procedures are borne by the hospital, the effect on the patient is minimal—though the effect on the tax payer is real though painless. We must remember that it costs a patient from $18.00 to $35.00 a day for a room in a hospital, plus the medication and laboratory tests. In having a patient in for a diagnostic workup, we can save them a hospital day or two by proper planning of x-ray and laboratory procedures.

By all means let us order what is necessary for the patient—and let us keep him in the hospital as long as necessary; but at the same time we should plan our hospitalization and procedures with a thought for the finances of the patient. Getting the patient out of the hospital a day or two sooner with no deleterious effects to himself will save him money and open up a needed hospital bed for someone on the waiting list.

Frank C. Owens, M. D.
Pres., S. C. Med. Association

Editorials

The State Chamber of Commerce

The South Carolina State Chamber of Commerce is rightfully known as the voice of business in South Carolina. It is interesting to see, however, how closely the interests of the medical profession are bound up in the work of this organization.

A current example is the work of the State Chamber opposing "Medicare" — certainly a position our profession shares. During recent consideration of the Medicare provisions of the Social Security Bill before Congress, the State Chamber reaffirmed its continuing opposition to such measures. Constant contact was maintained with the South Carolina Congressional delegation to urge defeat of this provision.

Interests of the State Chamber and the physician have followed the same path many times before. It was the State Chamber, working with a committee of the South Carolina Medical Association, that helped set up an equitable schedule of medical fees under the Workmen's Compensation Laws.

A current program of promoting economic understanding to schools, business, the professions and the general public will surely lead to a fuller understanding of our free enterprise system. Such knowledge is our best defense against increasing socialistic proposals.

Well known efforts of the State Chamber to aid industrial development have greatly added to the general prosperity of South Carolina.

It would be well for the physician to associate himself with the State Chamber of Commerce. The interests of the two are obviously close.

The following editorial, reprinted by permission from the *Journal of the Medical Association of Georgia,* describes a situation which is of vital concern to all medical journals, especially those of the state associations. ED.

The Paradox of Pharmaceutical Advertising

It must be obvious to most of our readers that the content of the JOURNAL has been reduced considerably in the past few months. This cutback in the size of our publication has not been dictated by a lack of available desirable material for publication, but of a marked reduction in our volume of advertising from the ethical pharmaceutical manufacturers. All state medical journals and many other scientific publications have suffered this cutback and have had to reduce their size accordingly. Yet we have noted an almost explosive growth of mass circulation, abstract types of publication. One look at these publications will confirm the fact that their growth is solidly underwritten by ethical drug advertising. It is ironic that the sources of much of the material published by these profit-inspired publications are being endangered by these reductions in advertising volume in the scientific journals.

Statistics may prove that because of the mass unpaid circulation of these abstract type publications, the advertising dollar of the manufacturer goes farther than in the scientific journals which provide the original material. From a physician's point of view this concept of the parasite ultimately consuming its host because of a "convincing advertising salesman's pitch" is basically unsound. Nevertheless, this paradox seems to have sense to the advertising executives who make these decisions.

We are all aware that the great majority of our scientific publications were begun and are maintained as the official organ of organizations of physicians. These journals are oriented toward basic scientific investigation or toward the clinical practice of medicine. The long time survival and growth of these publications provide eloquent evidence of their readership and influence with their readers. The fact that physicians pay money year after year for the privilege of receiving these journals suggest good evidence of their acceptance and readership. Such journals

have an editorial policy which reflects the basic interests and standards of their sponsoring organizations. Because of this, these publications command the respect and interest of the physician who ultimately prescribes the products promoted by the ethical pharmaceutical manufacturers.

With such a set of circumstances as outlined above, it becomes our obligation as physicians to be more aware of the role that has been so actively taken by the ethical drug firms in the support of our publication. If these firms are continuing to favor our journal with their advertising message, their representatives who call upon us in our offices should be made aware of our appreciation. If a detail man's firm is not advertising in our JOURNAL, a few gentle reminders to him will ultimately be transmitted to his company officials. Our visits to exhibit booths sponsored by pharmaceutical manufacturers at our scientific meetings will go far toward making these companies know of our interest and continuing support of their ethical products.

The House of Delegates of the Medical Association of Georgia at our recent Annual Meeting in Macon made official note of the importance of this relationship and specifically urged physicians to be more active in support of our advertisers. Let's all get their message and take appropriate action.

From J. Med. Ass. Georgia, 53:275 (August, 1964).

Committee on Legislation and Public Relations

This meeting was held in the Columbia Hotel, Columbia, South Carolina, September 30, 1964. Members present were Dr. C. Tucker Weston of Columbia and Dr. Donald G. Kilgore, Jr. of Greenville, Chairman. Ex-officio member present was Mr. M. L. Meadors, Executive Secretary and Counsel of the South Carolina Medical Association.

The first item on the agenda was a discussion of a "Battered Child" law for South Carolina as recommended by the House of Delegates last May. After examination of laws passed in various states it was recommended that the following points be included in a law for South Carolina.

1. That "abuse" should include not only physical injury but also deliberate or neglectful starvation as well as any other more subtle forms of child abuse.
2. That not only physicians but also nurses, teachers, lawyers, social workers and any other professional worker concerned with child care be required to report possible abuse.
3. That the matter be reported by telephone followed by written report to the juvenile court judge. If a juvenile court does not exist in the county, then the probate judge is to be notified.
4. That anyone participating in the making of a report persuant to the law be immune for any civil or criminal liability unless such a person acted in bad faith or with malicious purpose.
5. Failure to submit such a report should be considered a misdemeanor subject to not over 30 days imprisonment or $100.00 fine or both.

The Chairman was to see that this bill was introduced into the legislature.

The next item was a discussion of a law authorizing physicians and surgeons to perform sterilization operations providing permission be given in writing by the involved person and his or her spouse after a waiting period of 30 days. Such a law would also permit the performance of vasectomy or salpingectomy on any unmarried minor under the age of 21 when so requested in writing by such a minor providing that the circuit court of the county or the corporation court of the city in which such a minor resides, on a recommendation by the parents or guardian of a child, shall determine if the operation is in the best interest of such a minor and give a court order authorizing the physician or surgeon to perform such an operation. Subject to the rules of law applicable to negligence no physician or surgeon licensed by the state would be held liable for having performed a vasectomy or salpingectomy authorized by the provisions of this act. In essence, this follows the Virginia law on the subject.

The next item was a proposed law requiring mandatory seat belts on all automobiles sold in South Carolina after January 1, 1966. It was felt that this bill failed last year because it required seat belts to be installed in both front and back seats. If front seat belts only were required, it is felt that this law might have a better chance of passing.

A proposed law requiring periodic reexamination of drivers was to be studied regarding feasibility of passage. It was felt that at least an eye reexamination should be done. Members were urged to give this matter their consideration for the next meeting.

The Chairman introduced a letter from the President concerning the inclusion of blood in medical insurance policies. It was pointed out that the American Association of Blood Banks and the American Medical Association along with Blue Cross and those insurance Companies represented in the Health Insurance Council have all taken a stand that the volunteer donor is the backbone of this country's blood banks. When an insurance premium takes the place of the volunteer donor, the sources of good blood wither; and blood banks soon find they are almost required to take blood from unsatisfactory sources. The committee recommended opposition to blood donor insurance on a strictly monetary basis. However the committee approved any blood assurance plan where the individual member was given the option of donating blood or paying a specific fee.

Dr. Weston asked for the progress in obtaining a Medical Examiner Law for South Carolina. Mr. Meadors said that an opinion had been promised by the Attorney General but had not yet been forthcoming. It was mentioned that Dr. Strother Pope and Senator Walter Bristow had agreed to introduce such a bill into the Senate next year. Dr. Weston agreed to check on the progress of this collaborative effort.

Donald G. Kilgore, Jr., M. D., Chairman

News

Veterinarian Named To Board Of Health

Dr. L. D. Rodgers of Greenwood has been commissioned by Gov. Donald Russell as the veterinary member of the State Board of Health.

Dr. Rodgers, a veterinarian in Greenwood since 1944, is a former president of the South Carolina Association of Veterinarians.

Dr. Durst Elected By AAGP

Dr. George G. Durst, Sullivan's Island physician and professor of general practice at the Medical College of South Carolina was named president-elect of the state chapter of the American Academy of General Practice.

Dr. Durst will become president at next year's meeting, October 14-15, at Charleston.

Dr. Horace M. Whitworth of Greenville, president-elect last year, became president of the organization, succeeding Dr. William O. Whetsell of Orangeburg.

Dr. L. W. Luttrell of Spartanburg was named vice president; Dr. William J. Vernon of Simpsonville, secretary, and Dr. Rufus H. Cain of Dillon, treasurer.

Dr. George Price of Spartanburg was named delegate to the American Academy of General Practice and Dr. William Stuckey of Sumter was named alternate delegate.

New directors are Dr. Halsted Stone of Chester, Dr. B. M. Oliver of Lynchburg and Dr. Robert Holman of Elloree.

Dillon Doctor-Lawyer Meeting

The Pee Dee Medical Association was host to the local lawyers at the annual Doctor-Lawyer meeting on September 17th.

Speaker for the evening was Judge Julian Ness, Circuit Judge in the State of South Carolina.

Richland Medical Society Promotes Medical School in Columbia

The Columbia Medical Society has unanimously endorsed the prospect of a two-year medical school at the University of South Carolina.

Dr. John R. Harvin of Columbia, appearing before a legislative committee studying the feasibility of establishing medical and dental schools at USC, said the idea won unanimous approval from the society of 280 members, largest in the state.

American College of Surgeons

ATLANTA, GEORGIA. January 25-27. Sectional Meeting. Dr. Duncan Shepard, Local Chairman. Atlanta Biltmore Hotel.

ABSTRACTS INVITED

The Scientific Program Committee of the South Carolina Medical Association invites papers to be submitted for presentation at the annual session in May 1965 at Myrtle Beach. Abstracts should be typewritten double-spaced. Final selection of papers for the program will be made by the Program Committee.

Please mail abstracts to Dr. O. R. Talbert, Program Chairman, 55 Doughty Street, Charleston, S. C. prior to January 10, 1965.

Dr. Thomas Drake

Dr. Thomas F. Drake has begun practice in Pacolet.

He is a native of Anderson and attended the Citadel and graduated from the University of Georgia with a degree in Business Administration. He received his M. D. degree from the Medical College of South Carolina in Charleston and served his internship at the Baptist Hospital in Memphis, Tenn.

He began his practice in Abbeville and for the past two years has been practicing at Calhoun Falls.

Richland County Board of Health

New Richland County Board of Health includes Dr. John M. Preston, Health Officer, Dr. D. Strother Pope, and Dr. Chapman J. Milling.

Department of Continuing Education Medical College of Georgia

ELECTROCARDIOGRAPHY—January 19-21, 1965

Coordinator: A. Calhoun Witham, M. D., Professor, Medicine (Cardiology)

Southern Medical Association Annual Meeting

The 58th Annual Meeting of the Southern Medical Association will be held on November 15-19 in Memphis, Tennessee. Many South Carolinians will be participating.

J. Richard Allison, Jr. of Columbia, The Treatment of Venereal Disease . . . John van de Erve of Charleston, Tolnaftate in Dermatology: A New Potent Topical Fungicide . . . J. W. Jervey, Jr. of Greenville, General Practice and Ophthalmology . . . Lawrence L. Hester, Jr. of Charleston, Vaginal Hysterectomy and Partial Vaginectomy for Carcinoma *in situ* of the Uterine Cervix . . . Cheves McC. Smythe of Charleston, Pyelonephritis . . . Leon Banov, Jr. of Charleston, Proctology in Ancient Egypt . . . E. J. Dennis of Charleston, Septic Shock in Obstetrics: Some Problems in Management . . . J. Howard Stokes will serve as Vice-Chairman of the Section on Ophthalmology and as a member of the Council.

Institutes in the Care of Premature Infants

Institutes in the Care of Premature Infants are to be held at the New York Hospital - Cornell Medical Center in New York City during the coming year. The first institute for 1965 will be held on January 11 - January 22 with others scheduled for March 15 - March 26 and May 17 - May 28. Early application is essential. Write Dr. Hilla Sheriff, Director, Division of Maternal and Child Health, State Board of Health, Columbia, South Carolina, for further information.

Dr. Bradford Retires Dr. Eckles Succeeds Him

Dr. Cecil R. Bradford has retired as superintendent of the Medical Department of the Du Pont Company at the Savannah River Plant, and has been succeeded by Dr. Donald H. Eckles.

Dr. Bradford had specialized in occupational medicine for 39 years and had been at the Savannah River Plant since 1951. He is a past president of the Aiken County Medical Society.

The new Medical superintendent, Dr. Eckles is a native of New Castle, Pa. He was graduated from Amherst College and the Harvard University Medical School. He later earned a master's degree in public health from the University of Pennsylvania.

He is a diplomate of the American Board of Preventive Medicine and is secretary-treasurer of the Aiken County Medical Society. He is director of the Aiken County Red Cross Chapter and serves as a volunteer physician in charge of bloodmobile visits.

Dr. Dreisbach Appointed Physician To Bob Jones

Dr. John A. Dreisbach has been named resident physician at the Bob Jones University. A 65-bed hospital with operating room facilities is maintained by the university.

A native of Columbus, Ohio, Dr. Dreisbach has served for 16 years as a medical missionary in Africa under the Sudan Interior Mission. In Nigeria he was superintendent of Kano Leprosarium, one of Africa's leading research centers for leprosy.

Dr. Dreisbach received his undergraduate work at Findlay College, Findlay, Ohio. Ohio State University College of Medicine, Columbus, Ohio, conferred upon him the degree of doctor of medicine in 1946. He also has studied at the Biblical Seminary in New York City and has just completed his last year of orthopedic training at Riverside Methodist Hospital in Columbus. He is an ordained minister having received his ordination at the Calvary Bible Church in Columbus. In addition to his medical duties on the mission field, Dr. Dreisbach pastored a mission church.

A member of the International Leprosy Association, Dr. Dreisbach has written numerous articles on leprosy and was a contributing editor of the outstanding English language text on leprosy.

Dr. Dreisbach will also teach at the university and will concentrate on training nurses who are preparing to become medical missionaries. In addition to his duties at the university, he will be associated with Dr. Robert C. Grier, Jr. of Greenville in the practice of orthopedic surgery.

Doctors in the News

Dr. Leon Banov, Jr. of Charleston has been elected President of the Piedmont Proctological Society.

Dr. J. Pierce Horton, Jr. spoke on September 8 to the graduating practical nurses in Lancaster.

Dr. Frank Owens, President of the South Carolina Medical Association, was guest speaker for the meeting of the executive board of the Woman's Auxiliary to the South Carolina Medical Association. Mrs. C. Benton Burns, President of the Auxiliary, presided at the sessions which were held in Sumter.

The American Cancer Society has awarded Clinical Fellowships in Surgery at the Medical College of South Carolina. The fellows are **Drs. James Franklin Green** and **James Thompson Richards. Dr. George H. A. Clowes, Jr.** has been awarded a fellowship for 1965-66.

New Fellows of the American College of Surgeons were inducted at the 50th Annual Clinical Congress on October 5-9 in Chicago. South Carolinians receiving these Fellowships were **David E. Cowan** and **Henry B. Gregorie, Jr.** of Charleston, **David E. Tribble** and **Andrew J. Whitaker** of Columbia, **Marvin M. Kirchner** of Fort Jackson, and **Wendell M. Levi, Jr.** of Sumter.

America's Number One Epidemic

A peculiarly American disease, so statistics tell us, is our national and apparently insatiable desire to destroy ourselves in automobile accidents.

As crash deaths and injuries mount, the obvious solution to this mania for self destruction lies in two areas—the driver of the automobile and the machine itself.

Imperative Education

Numerous programs, on national and local levels, are aimed continually at driver education—"Slow down and live" or "The life you save may be your own." It is obvious that driver training and education are imperatives, but as in any attempt to modify human attitudes, the progress is slow. Automobile accident fatalities continue to mount in spite of official and voluntary efforts to turn the tide. We can only speculate at how high the statistics would soar if there were no driver education programs or accident prevention safety campaigns to hold deaths in check.

The other basic approach—concurrent with attempts to solve the human problem—is to the great big shiny machine the peculiarly motivated American uses to hurl himself down highways and byways.

The Measures

What can be done to the automobile itself to make it optimumly safe? What can be done through research and manufacturing skill to protect the driver, perhaps against himself, while others are working on his aptitudes and attitudes?

Four South Carolina groups, in cooperation with Cornell Aeronautical Laboratory of Cornell University, are working on the answers to these questions. The South Carolina Medical Association, the South Carolina Highway Patrol, the South Carolina Hospital Association, and the South Carolina State Board of Health are the participating agencies. Hilla Sheriff, M. D., Director, Maternal and Child Health Division of the South Carolina Board of Health is serving as medical coordinator of the project.

The initial three-year Automotive Crash Injury Research (ACIR) study in South Carolina is to end on May 31. During this initial study, a concerted effort was made by the cooperating agencies to report on all rural injury-producing accidents involving passenger cars in selected sampling areas of South Carolina. With the approval of South Carolina agencies an additional three-year study is to begin June 1, 1964, during which only those injury-producing accidents in selected areas that involve passenger cars of the last four years' models will be studied. As in the first study, the limited study is to be conducted in the seven highway patrol districts for a six-month period as indicated:

Period	Date	District
1	6/1/64 - 11/30/64	#6 Charleston
2	12/1/64 - 5/31/64	#4 Chester
3	6/1/65 - 11/30/65	#5 Florence
4	12/1/65 - 5/31/66	#2 Greenwood
		#7 Orangeburg
5	6/1/65 - 11/30/66	#1 Columbus
6	12/1/66 - 5/31/67	#3 Greenville

These are South Carolina Patrol district area headquarters and serve as field coordination points for the six field studies; only specified accidents investigated by the State Patrol are within the scope of the study.

The ACIR project in South Carolina, to determine how automotive design can contribute to passenger safety, will succeed or fail on the basis of reports supplied by South Carolina physicians and State Troopers.

In Detail

The information from the State Patrol covers in detail the conditions surrounding the accident itself: road design, type of road, surface conditions, number of vehicles involved, estimated speeds, details of external damage to the involved vehicles, objects struck by occupants. Additional information is supplied by State Troopers on interior damage to the automobile, and photographs, when needed, will supplement the written report.

Step two in the chain of field research is the completion of the ACIR medical report form by the physician attending the accident victim. The form, which takes less than five minutes to complete, is given by the investigating patrolmen to the attending doctor or to the emergency room supervisor of the hospital to which the accident victim is removed. A separate medical report is submitted for each injured person; stamped self-addressed envelopes are supplied to physicians and hospitals to simplify submission of reports.

Coordination of reports from troopers and physicians is done in Columbia by the State Board of Health. The package of field data is transmitted to Cornell Aeronautical Laboratory of Cornell University for intensive study. The physicians' reports are considered privileged medical information.

Will Not Disappear

Information from previous ACIR studies did not disappear into a statistical lost forest. Many life saving features on the automobiles of 1964 came from these and similar studies. Strengthened door locks, recessed steering wheel posts, padded dash boards and sun visors and, of course, safety belts—now required by law on new cars in South Carolina—are life saving devices that might not be on our new cars without field research.

The need is obvious; the goal important and dramatic. For these reasons the South Carolina Medical Association commends and supports the Automotive Crash Injury Research program.



THOMAS BROCKMAN, M. D.

J. Decherd Guess, M. D.

The thesis of this sketch is that the best defense against the debilitating ravages of age is the maintenance of a youthful outlook, a continuing interest in one's fellow man, with no lessening of one's mental activities, and no withdrawal from the stream of human endeavor.

Thomas Brockman was 81 years of age on October 11. He was interviewed by this reporter in his office on Labor Day, a holiday for most of his medical colleagues.

The doctor sat in the little office suite into which he had recently moved from a much larger establishment. The office was immaculate, as was the doctor. His face was a ruddy hue, he sat and stood erectly. His eyes were bright and his mind was clear. He answered promptly and accurately all questions regarding his long life which had been filled to the full with human experiences. During the interview, his chief difficulty was in restraining an impulse to pass from one experience to another which had been suggested to his active mind, so filled with recollections.

Childhood and Education

Tom was born and reared on a farm in the Reidville community of Spartanburg county. At least five other prominent South Carolina physicians came from Reidville at about the same time. Tom attended Reidville Male High School, which was operated for many years by Professor George Briggs. Professor Briggs appears to have been an excellent and stimulating teacher.

After finishing high school, young Brockman was awarded the contract to open and operate the first rural free delivery mail route out of Greer. Fortunately for Tom and for South Carolina medicine, Dr. H. V. Westmoreland took the young man into his home as a boarder and treated him as if he were a son. The doctor had a large and widely scattered practice, while Tom had his afternoons and evenings free. He was soon riding the medical circuit with Dr. Westmoreland. It was not long before he was not only driving for the over-worked doctor, but he was acting as the medical assistant and learning many of the techniques of applying medical treatment. While serving as an informal medical apprentice, the urge to study medicine became compelling. Tom resigned his rural mail route and entered Furman University in order to further that ambition.

After one year at Furman he enrolled in the old Atlanta School of Medicine. Having been granted a scholarship by the governor, he transferred at the end of his freshman year to the Medical College of the State of South Carolina, from where he graduated in 1909. He stood fourth in a class of forty-two. As we talked of his life in Charleston, where he was exhilarated by the life of a medical student, he recalled many of the experiences of a country boy thrown suddenly into the life stream of that sea port city.

One of his most poignant recollections was his first clinic on heart diseases, conducted by Dr. Robert Wilson. At that time, he learned to say, 'I do not know', and the necessity of careful clinical observation and examination in attempting to make a diagnosis. This necessity has been a guiding principle throughout his medical career.

A second impression was his association with Dr. Francis L. Parker. Dr. Parker was a classmate. He was also a highly trained chemist, the professor of chemistry at the College of Charleston, the owner of a highly regarded clinical laboratory, and State Chemist and Toxicologist. Because of Dr. Parker's manifold duties, this Charleston aristocrat and scholar was forced to cut many of his medical classes. Because of these cuts his lecture notes, so important to the medical student of that day, were rather meager. He had noted how well his classmate, Brockman, answered up on the frequent quizzes and how assiduously he recorded notes on the lectures. He asked that Tom assist him in his studies. Thus began a long and intimate association between these two men of such different educational preparation and such different social backgrounds. Tom became the tutor in medical studies and an observer and a learner in Dr. Parker's home of education and culture.

Impulsive Man

Tom Brockman has always been an individual of strong impulses, and these impulses often resulted in vigorous and decisive action. Near the beginning of 1964, his impulse was to retire from medical practice, and he so announced. However, as the days and weeks passed, he found it almost impossible to pull himself away from his long time patients who continued to come to him for counsel in so many problems of their lives. Realizing that he felt as well and that he was as physically and mentally active as he had been for some years, he postponed retirement for another year. An important factor in that decision and one of the greatest joys of his life has been his work

in proctology with the residents of Greenville General Hospital. At the request of a group of these young doctors, he has continued to be present at all of their operative ano-rectal clinics. He directs and guides their observation and their surgical techniques.

This calls to mind a much earlier observation which led up to a major decision. In those days, Dr. Brockman served as operating assistant to the late Dr. D. B. Steedly, who operated the Chick Springs Hospital. Dr. Brockman had within a short period of time seen some eight or ten cases of post-operative anal stenosis, some of which Dr. Steedly had operated upon. Tom went to him and discussed these cases and suggested that they attempt to ascertain the faults of techniques which were no doubt responsible for the strictures. So began a period of joint research by the finished and experienced surgeon and his general practitioner surgical assistant.

Proctologist

Dr. Brockman's interest and thought now became directed towards rectal surgery. He soon noted that in his practice there was a dread of and a dissatisfaction with the results of such surgery. He learned of a Dr. Pennington, who practiced in a small community in Tennessee and to whom had gone a number of patients from the Greer area for the injection treatment of prolapsing and bleeding hemorrhoids. Tom interviewed each one of these people and found them to be not only satisfied but enthusiastic over the results they had received from Dr. Pennington's treatment. Quack medicine though it was reputed to be, it was producing cures without unpleasant complications or sequelae. Dr. Brockman paid Dr. Pennington a visit, observed the conditions he was treating and his method of treatment. He talked with patients from several states whom he found in Dr. Pennington's clinic and he even subjected himself to treatment. He came away convinced of the value of the injection treatment of hemorrhoids as a palliative and often a curative method of treatment. Thus his career as a proctologist had its beginning. After several months, he was able to report to his district medical society 300 cases of hemorrhoids treated by injection. His report and its discussion, some of which was sarcastically critical, was convincing to many of the doctors who heard him. Dr. Brockman was on his way to wider service, to respect, and to success.

He visited for varying lengths of time a number of the leading proctologists of the country including Gantt of New York, Hirschman of Detroit, Terrell of Richmond, Buie of the Mayo Clinic and Gaston of Birmingham. There was not one of these prominent proctologists but who received cordially this earnest and interested student and not one of whom but became his life-long friend.

In 1926, Dr. Brockman limited his practice to proctology and in 1932 he moved to Greenville.

Medical Society Service

In 1938, Dr. Brockman became president of the Greenville County Medical Society. This was a time of ferment in organized medicine of South Carolina. In preparation for his tour of duty as president he visited the Richland County Society. The Columbia Society was already publishing *The Recorder*, and each month it heard a lecture by a carefully selected medical educator. Tom came back determined that his society should inaugurate a similar program.

The new president had soon sold the Greenville Society on his ideas. *The Bulletin* was established to serve primarily as "a letter from home" for its members who were away in service and the program committee lined up a full roster of outstanding and experienced medical teachers for the monthly programs.

State Medical Association Service

In 1946, Dr. Brockman was elected president of the South Carolina Medical Association without opposition. He was the only recent president of that association destined to serve for two successive years. It was war time. Gasoline was rationed. All unnecessary meetings were interdicted. It was decided by the Council of the Association to allow President Brockman to carry over for another year. He ascribed his election to the presidency of the state Association to the work he had done in his county society and to his long time successful attempts to heal breaches of friendship among its members and to instill in them an *esprit de corps.*

Brockman, The Man

Dr. Thomas Brockman has always been a very kindly man and one who instilled friendship and confidence in his acquaintances. A sick and suffering child always touched him deeply. After he had been in practice only about two years, diphtheria became epidemic in his territory. There was no known cure. "Membraneous croup" was a frequently terminal condition. There was relief for this, but none of the family doctors was skillful in its use. A nose and throat specialist had to be called from the city to do intubation and he frequently arrived too late.

After the epidemic finally burned itself out, Dr. Brockman enrolled in the New York Polyclinic Hospital where he stayed three months to learn the technique of laryngeal intubation. His new skill served to save many children.

People have learned to come to Dr. Tom for advice and counsel on many problems. They have never been turned away without comfort, even though the advice may not have solved their problems.

Politics

A man with so many friends, with so great a reputation for wisdom, and with such a drive to aid his followers often gravitates naturally to elective office. So with Tom Brockman. He was elected a councilman of Greer in 1918 and he served out the term of the mayor who had to resign in 1920.

In 1941, he was easily elected to the City Council of Greenville. Because of the financial stress of children in college, he did not offer for re-election. However, he ran again successfully in 1959 and he has been re-elected twice since that time. He has been a valued, conscientious, and able councilman.

Such have been the motivations and the activities of this good man of South Carolina medicine. However, as was noted by Wordsworth, "The best portion of a good man's life is his little, nameless, unremembered acts of kindness and of love." Of these, there was no reference by Tom in our interview, but they have been an important reason for the esteem in which he has been held.

ARMY RESERVE PROGRAM FOR THE MEDICAL PROFESSION

Robert E. McCall, M. D.
Columbia, S. C.

The tradition of the citizen soldier began with the minute-men in the American Revolution who subsequently have proved their worth many times throughout the history of our country. In this century alone, the US Army Reserve has played a decisive role in three major conflicts: World War I, World War II, and the Korean Conflict. Even today, the country's security depends to a large measure on the strength of the citizen soldiers in the Reserve.

Unfortunately, that strength is not what it should be, for there is a critical shortage of doctors and nurses in the medical units of the Reserve program. In time of war, the doctors, dentists, nurses and medical technicians of America have shown superb competence and courage, but in times of peace they have not responded to the nation's military needs in sufficient numbers. The lack of a fully staffed medical complement to provide and administer the necessary medical requirements reduces our efforts to maintain a strong and effective Reserve as a major deterrent in our national defense posture. A prime factor in our winning a "cold" or "hot" war is our ability to present to the world in general, that we, as a nation, have the resources and are prepared to meet any contingency. In this regard, we cannot adopt a convincing posture unless *all* elements of national security contribute their share to the overall defense picture. This again invokes the need for greater participation by the men and women who are qualified to provide the medical support for our Reserve forces.

The state of South Carolina has within its confines three U S Army Reserve Hospital Units located at Charleston, Columbia, and Greenville, along with two other smaller type medical units; a Medical Dispensary and a Dental Detachment. These units provide many opportunities for personnel of the medical profession to further their military and professional careers.

In many instances, members of the medical profession have not been completely informed as to the advantages and benefits which accrue to members of the Reserve program. To clarify this general comment to some degree, a physician or nurse can be appointed to a commissioned rank dependent upon the person's age and qualifications. Subsequently, he can expect periodic promotions. A physician must be a graduate of a recognized school of medicine, have completed 12 months of internship or residence training, and must be licensed to practice medicine in the United States. A nurse must have graduated from a recognized school of nursing and must be registered to practice nursing in the United States.

For the younger physician who is subject to the draft, active reserve assignment fulfills his obligation without further action.

Normally, meetings of USAR units are conducted two weekday evenings (each of 2 hours duration) and one 8 hour Sunday drill per month, making a total of 48 authorized drills per year. For each two hour drill, a full day's pay is received and for an 8 hour Sunday drill, two day's full pay is received. For the medical officer, who, because of the exigencies of his private practice, cannot attend all 48 drills scheduled, there is a mandatory minimum of only twelve per year. In addition to the unit drills, it is required that the officer concerned attend two weeks of active duty training with his unit. Furthermore, the medical officer who lives in a community some distance from the hospital to which he is assigned may be attached to any type army reserve unit (i.e. Infantry, Artillery, etc.) for attendance at its drill for both retirement credit and pay.

The medical officer who retires with 20 or more years of creditable service will upon reaching age 60, receive a substantial monthly retirement pay for as long as he lives. The amount, of course, depends on his rank and length of service.

Detailed information concerning the active Reserve medical program can be obtained from any U S Army Reserve Center.

The American Medical Association, with the cooperation of each state Medical Society, is in a position to acquaint members with the urgent need that exists for members of the medical profession and the openings that are available in this field. Local medical societies and the staffs of all medical colleges and nursing schools should emphasize the importance of this opportunity to serve as members of the U S Army Reserve.

Office space available October 1, Charlotte, N. C. Occupied by otolaryngologist for fifteen years. Secretary with fifteen years service this office available if act quickly. Ernest Franklin, M. D. 1324 Scott Avenue.

DO YOUR PATIENTS KNOW THE FACTS ABOUT KERR-MILLS?

While the effort to pass the King-Anderson Bill is temporarily inactive, it is most likely that this proposed legislation or some modifications of it will be introduced into the next Congress. If you can inform your patients of the benefits of the Kerr-Mills Act and the desirability of adhering to this form of medical assistance to the aged, the public may be willing to express its support of the current Act and show a disinclination for the proposed bill.

Under the present administration of the Kerr-Mills Act in South Carolina eligibility is based on the following—

An individual whose annual income from all sources does not exceed $1,400 and who has not more than $500 in savings is financially eligible. In the case of husband and wife living together, the maximum annual income exempted from consideration is $2,400 and savings of $800. The cash surrender or loan values of life insurance policies in excess of $1,000 for an individual or $2,000 for a couple must be taken into consideration in estimating available income. One's homestead is exempt from the application of the program, but rental or other property must be considered as a resource in determining financial eligibility.

Under the Act the following benefits are available—General hospital care is made available to those persons certified by a physician as being acutely ill, injured, or having a sight-endangering condition, and hospitalization is essential for treatment.

There is no provision for physician or surgeon fees or the expenses for special nurses.

A maximum of 20 days is allowed on the initial authorization. This may be extended upon the certification of the attending physician that additional hospital care is necessary. In no case, however, may the total number of days in any one fiscal year exceed 40.

Nursing care may be provided when the attending physician certifies that the patient is in need of continued professional nursing care which cannot be made readily available in the recipient's home after release from the hospital. Except in unusual cases, this period should not exceed 3 months and if extension proves necessary, it is on a month-to-month basis.

Those eligible for MAA may receive out-patient medical care such as emergency treatment, organized clinic service, special diagnostic and therapeutic services, laboratory and X-ray procedures, intravenous solutions, electrocardiograms and minor surgery. These non-institutional benefits are limited to not more than 3 visits during any 31-day period.

It is quite possible that the range of the Act may be increased inasmuch as each state establishes its own regulations.

If at all possible, an application should be cleared through the County Department of Public Welfare before the actual need for medical care arises.

TELL YOUR PATIENTS WHAT THE KERR-MILLS ACT OFFERS.

Deaths



Dr. L. P. Thackston

Lawrence Phillips Thackston, M. D., President of the South Carolina Medical Association in 1952, died in an automobile accident on October 20, 1964.

Born April 18, 1899, in Orangeburg County, he pursued his education in local schools and graduated with a B.S. in Chemistry at Clemson College. While in school he was an outstanding athlete. After graduating from the Medical College of South Carolina in 1924, he served in house staff positions in Roper Hospital and the Orangeburg Hospital and continued his medical education at Columbia University Post-Graduate Medical School. He served one year on the urological staff of the New York Post-Graduate Hospital. Returning to Orangeburg, he engaged in the practice of urology and in 1937 established the Urological Institute as a private venture. Later this institute, a fully accredited hospital, was merged with the Orangeburg Regional Hospital.

Dr. Thackston served as director of the Institute and was a frequent contributor to the medical literature. During his career he was invited to a number of foreign cities, such as Paris and Rio de Janeiro, to deliver urological papers.

He served in World War I as an enlisted man before he had studied medicine. In World War II he served with distinction in the Medical Corps and received the Bronze Star and the Purple Heart decorations, completing his army career as a colonel. He has held many positions in medical organizations, having been a president of the Southeastern Section of the American Urological Association as well as president of the South Carolina Medical Association. He was state regent of the International College of Surgeons, a fellow of the American College of Surgeons, a diplomate of the American Board of Urology, and a member of the honorary medical fraternity Alpha Omega Alpha. He was also at one time a trustee of the Medical College of South Carolina and was connected with numerous fraternal and social organizations.

Dr. A. L. Ballenger

Dr. Albert Lee Ballenger, 83, died in Batesburg, September 19, after an illness of three years.

He had practiced medicine for 30 years in Batesburg-Leesville, Monetta and Wagener. He had been retired for the past 20 years.

Dr. Ballenger studied at the University of Georgia, and did post-graduate work in Chicago.

He was a past president of the Middle State Medical Society and the Lexington County Medical Society. He was a member of the American Medical Association and the South Carolina Medical Association.

Dr. A. P. Polgar

Dr. A. Paul Polgar, 70, a retired physician died September 25 at Camden following an illness of several weeks. Dr. Polgar practiced internal medicine in New York for 35 years. He was born in Czechoslovakia and attended Medical Schools in Vienna and Geneva and served with the Allies in Austria during World War I.

Dr. C. L. Guyton

Dr. Clarence Lee Guyton, who devoted most of his medical career to public health work, died of a heart attack at his office October 8.

The 64-year-old physician was assistant state health officer at the time of his death. He was the first director of the State Board of Health's cancer division and later headed the board's divisions of venereal disease, hospital construction and public health education.

Dr. Guyton, a native of Williamston, practiced medicine in Chesterfield County and Monroe, N. C., before going with the state board of health as Colleton County Health Officer in 1936.

Dr. Guyton attended the College of Charleston and was a graduate of the Medical College of South Carolina.

Dr. E. B. Burroughs

Dr. Edward Butler Burroughs, who practiced medicine in Charleston for 45 years died October 18.

Born in Cheraw, he graduated from Claflin University and received his medical training at Boston University School of Medicine. He later trained in

pediatrics at Meharry Medical School and at Children's Hospital in Chicago.

Dr. Burroughs served for 20 years as medical examiner for the Boy and Girl Scouts and for 18 years was physician for School District 20 in Charleston.

He was a member of the Charleston County Medical Society, the Palmetto State Medical Association, and several local civic organizations.

Book Reviews



THE LIVER AND PORTAL HYPERTENSION, by Charles G. Child, III. W. B. Saunders Company, Philadelphia and London. 1964. Pp. 231. $8.50.

This book is Volume I in the series *Major Problems in Clinical Surgery.* This series is intended to bring to practicing surgeons a current report of the basic concepts and technical approaches to controversial surgical problems. The first volume is a classic account of portal hypertension and will serve as an immediate practical guide to treatment and as a reference work of value for future investigative studies in this field. Its author, Dr. Charles G. Child, III, is Chairman of the Department of Surgery of the University of Michigan Medical Center. The book is written in collaboration with numerous members of the departments of Surgery and Medicine of the University of Michigan. The author and several of the collaborators have made many important contributions to the understanding of the hemodynamics and metabolism of the normal and diseased liver.

The first chapter, which consumes more than one third of the volume deals with the diagnosis and management of portal hypertension when it is complicated by bleeding esophageal varices. Diagnostic procedures, an understanding of the etiological concepts, management of the hemorrhage, and definitive procedures that effect portal decompression are lucidly described. The management in the immediate and late postoperative period, especially of those patients having cirrhosis, is outlined.

Other chapters deal with the problems of hepatic failure and hepatic encephalopathy. Protein, salt, water, and adrenal steroid metabolism are presented in a very understandable manner. Dietotherapy in hepatic disease is discussed in detail. In the last chapter, the highlights in the evolution of modern knowledge of the extrahepatic circulation of the liver are outlined. These should form the basis for a better understanding of present knowledge of liver physiology and guidance for future investigation in this field.

R. Randolph Bradham, M. D.

THE PROSPECT OF IMMORTALITY. By Robert C. W. Ettinger. Doubleday & Company, Inc., New York. 1964. Pp. 190. $3.95.

In these times when there is global concern over overpopulation, the author proposes that the current and future population gradually could be preserved by refined techniques of freezing and could be brought back to life at will in a state of rejuvenation.

Evident confidence in a sustained advance of human technology is the basis for the thoroughly expounded thought that the potential technical, legal, moral, and religious difficulties can be overcome. The thought that Social Security might solve financial obstructions is expressed; the citizen would then be covered from the cradle to the freezer.

There are many interesting facets to this proposal, in which we do not care to be included, unless a more convincing promise of performance can be offered.

JIW

GASTROENTEROLOGY, Volume II, by Henry L. Bockus, M. D. W. B. Saunders Company. 1,241 pages. 350 illustrations. $28.00.

This second of three volumes in this, the world's most definitive work on gastroenterology, carries on the standard set by the revised volume I.

Volume II deals with diseases of the small intestine, disorders of absorption and nutrition, anemias in gastrointestinal disorders, diseases of the colon and of the peritoneum, mesentery, and omentum. As one would expect, the material in this volume is almost completely rewritten from material found in the monumental three volume work first published in 1944. The many advances in the fields of cytology, radiology and biochemistry as they relate to gastroenterology have made this revision a necessity.

The material presented is extremely well written and well organized, with each chapter preceded by a detailed outline of its contents. Discussion of specific processes include causative factors, clinical features, diagnostic aids, differential diagnosis and therapy. Illustrations are used frequently and many of these are in color. Complete new sections on such recently recognized entities as protein-losing gastroenteropathies are included.

It is felt that this three volume set (volume III will be ready in January of 1965) is a "must" for every gastroenterologist and certainly should be available for every internist and abdominal surgeon. In addition it will serve as a definitive reference for every practicing physician who in any way encounters a gastrointestinal problem.

Clarence W. Legerton, Jr., M. D.

PEPTIC ULCER • FUNCTIONAL HYPERMOTILITY • IRRITABLE COLON

PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS



PRO-BANTHİNE (propantheline bromide) Assures Authoritative Anticholinergic Control in Gastrointestinal Dysfunctions

The clear and consistent therapeutic benefits of Pro-Banthine (propantheline bromide) have made it the preferred anticholinergic for the past decade.

During that time, many compounds have been developed and proposed as alternatives. In the appraisal of Roach[1] "... few, if any, have seemed to offer a distinct improvement, ..."

Early investigations showed that Pro-Banthine (propantheline bromide) reduces motility and acid secretion and may be used in a wide range of dosage, to bring prompt, positive anticholinergic benefits to patients with peptic ulcer, spastic colon, pylorospasm and related gastrointestinal dysfunctions.

Recent evaluations sustain these earlier judgments. In a current authoritative assessment based mainly on the factors of potency, superiority to atropine, clinical experience and physiologic study, Steinberg and Almy[2] select as the first two preferred anticholinergic drugs, methantheline [Banthine] and propantheline [Pro-Banthine].

The name Pro-Banthine (propantheline bromide) sets a stamp of therapeutic authority on any anticholinergic prescription.

Side Effects and Precautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Dosage—The usual adult dosage is one tablet of 15 mg. with meals and two at bedtime; this amount may be doubled or tripled for patients with severe conditions. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

SEARLE

Chicago, Illinois 60680

Research in the Service of Medicine

1. Roach, T. C.: Therapy of Peptic Ulcer, J. Louisiana Med. Soc. *115*:136-139 (April) 1963.
2. Steinberg, H., and Almy, T. P., Drugs for Gastrointestinal Disturbances, Chapter 21, in Modell, W. (editor): Drugs of Choice —1964-1965, St. Louis, The C. V. Mosby Company, 1964, p. 343.

PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS

PEPTIC ULCER • FUNCTIONAL HYPERMOTILITY • IRRITABLE COLON

CHRISTOPHER'S TEXTBOOK OF SURGERY. Edited by Loyal Davis. Eighth Edition. W. B. Saunders Company. 1964. Pp. 1481. $18.50.

This is a multi-author textbook oriented toward undergraduate medical students. The contributors are well qualified as teachers as well as surgeons. Basic principles are emphasized in etiology, diagnosis and treatment, likewise the relationship of basic science to surgery. A number of diagrammatic drawings add to the clearness of the presentation. Operative principles are given, but, very properly, there is very little on the technical performance of operations.

It has sections on orthopedic and gynecological surgery, and brief chapters on the eye and the ear.

There are well written chapters on the philosophy and morals of surgery and a fascinating chapter on the future of surgery.

In brief, it gives the student a proper approach to the study of surgery.

William H. Prioleau, M. D.

EATING FOR GOOD HEALTH, by Frederick J. Stare. Doubleday & Company, Inc., New York. 1964. Pp. 239. $4.50.

The author of this book, which is directed at the public, has an outstanding reputation for his knowledge of nutrition and his willingness to battle in the field against faddism. The book is a straightforward consideration of the accepted principles of nutrition, with some pungent comment on the gullibility of health food addicts. The customary diet lists for weight control are included.

An excellent book for the patient, direct but a bit short on humor—which perhaps is not a fault.

JIW

INCURABLE PHYSICIAN, AN AUTOBIOGRAPHY, by Walter C. Alvarez, M. D. Prentice Hall, Inc., Englewood Cliffs, New Jersey. 1964. $4.95.

A well written and absorbing account of the life of a man who has contributed much to medicine in a scientific and a popular way. It includes an interesting account of experiences at the Mayo Clinic. Its discussion of the faith of a physician is not for fundamentalists, though perhaps it should be. A chapter on "decerebrate medicine" is pertinent for the physician with the heavy hand on the laboratory order sheet, and a final blast hits the psychoanalysts in all the right places.

JIW

ATLAS OF GENERAL SURGERY (Second Edition), by Joseph R. Wilder. 317 pages. The C. V. Mosby Company, St. Louis, 1964. $25.50.

This book was originally published for the use of medical students and house officers. Now, in addition, it includes techniques and concepts applicable to all surgeons. The 103 operative procedures are superbly illustrated with photographs and drawings, and are amply described in outline form.

Besides the usual operations practiced in general surgery, there is an excellent section on gynecological, tendon, and vascular surgery. The techniques demonstrating venous and direct angiography are outstanding.

The book should be available, as part of the operating room equipment, to all medical students, house officers, and surgical nurses. It is equally as useful as a ready reference for advanced surgeons.

J. Manly Stallworth, M. D.

THE ADOLESCENT IN PSYCHOTHERAPY by Donald J. Holmes, M. D. Little, Brown and Company, Boston. $9.50.

A minimum of the usual psychiatric jargon is found in this rather informal and speculative book about "The Adolescent in Psychotherapy." "Adolescents, Adults, and Psychotherapists," "Individual Psychotherapy," and "Residential Treatment for Disturbed Adolescents" are the three sections. They indicate the vast scope and interest of the author who is widely recognized in the field of adolescent psychiatry. Frequent utilization of adolescent clinical cases are made throughout this interesting book and are appropriately associated with the concepts offered.

Practical literature pertaining to the psychiatric patient and especially the adolescent is rare and Dr. Holmes's book will be read with interest by medical and para-medical personnel in their attempts to understand and assist the adolescent. In future editions it is hoped that more rigorous editing of sometime belabored points will eliminate to some degree this distraction from the valuable contribution of the author.

R. Ramsey Mellette, Jr., M. D.

CASE STUDIES IN OBSTETRICS AND GYNECOLOGY, by F. Jackson Stoddard, M. D. W. B. Saunders Company, Philadelphia. 1964. Pp. 312. $8.50.

This small volume is a definite addition to the obstetrical and gynecological literature and contains a wealth of information about most of the major problems encountered. The information is presented in an interesting and concise manner.

I felt that the most interesting part of the book was in the first several cases which had to do with endocrine problems. The only criticism I have of this book is that the manner in which some of the aspects are handled is somewhat outdated already, specifically the management of the menopause.

All in all, I think the book is well worth the time that would be devoted to reading and studying it, and especially for doctors at the intern and residency level.

L. N. Bellew, M. D.

HANDBOOK OF LEGAL MEDICINE. 2nd Edition. By A. R. Moritz, M.D. and C. J. Stetler,

L.L.B. C. V. Mosby Co., St. Louis, 1964. 233 pages. $5.75.

The second edition of this handbook presents some revision of the text and a change in the junior author. It again considers the two aspects of medicine supporting the accomplishment of justice and of the doctor meeting his legal requirements.

The contents of the book are divided into scientific medico-legal investigation and the responsibility of the physician to the patient and to the law. The section on scientific investigation treats such considerations as how to identify a body, establishing the time of death, determining the cause of violent or unexplained death and a discussion of specific injuries as rape, poisoning, etc.

The physician's responsibility to the patient is illustrated by drawings and by questions and answers to show frequent sources of medico-legal liability. The responsibility of the doctor to the law embraces such diverse items as professional civil and criminal liability, medical partnerships, medical societies, reports and testimony.

The work suffers from the fault common to all introductions to a subject as large as legal medicine. The authors apparently feel their work must be an all-inclusive summary of the legal aspects of medical practice and thereby tend to fall into superficialty.

The work is clearly written and is designed to appeal to undergraduate and immediately postgraduate students as a primer. To physicians doing general work it will serve as a ready reference and ordinary guide through the legal maze.

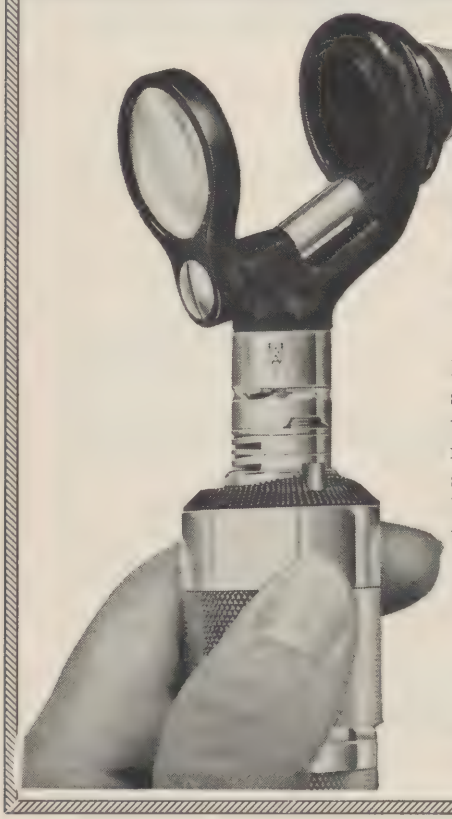
Louie B. Jenkins, M. D.

THE BUSINESS MANAGEMENT OF A MEDICAL PRACTICE. Bernard D. Hirsh, LL.B., Director, Law Department AMA. The C. V. Mosby Company. St. Louis. $7.75.

The increasing trend toward group practice makes this a timely volume. It includes much useful information on the business inter-relationships of the practice of medicine. While these are especially important in group practice, much of the material presented is also important for solo practice.

The author writes from a wide experience on this subject. The topic is well and concisely covered. There are included many examples of written contracts suggested for use as guides. Written agreements or contracts are urged as essential for all business agreements. Various types of partnerships or associations are discussed. This makes an excellent reference book for the young physician planning his career and also offers valuable business and estate management and tax information for the established practitioner.

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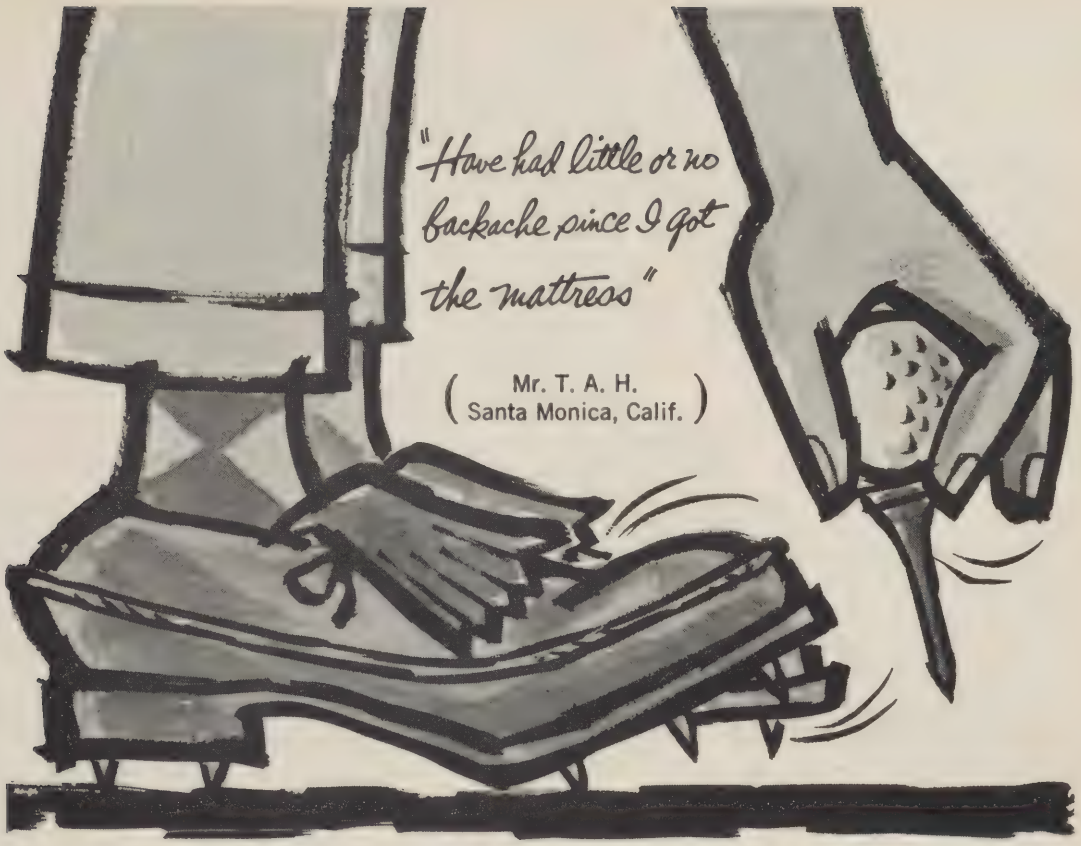
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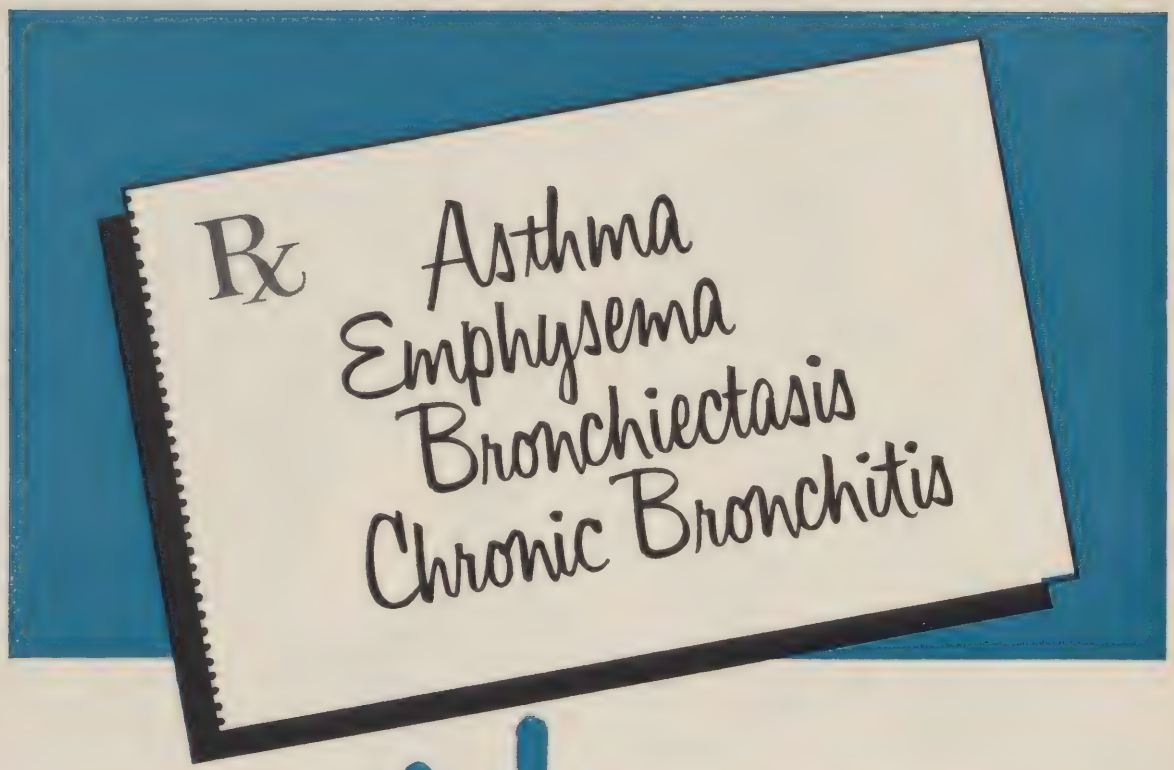
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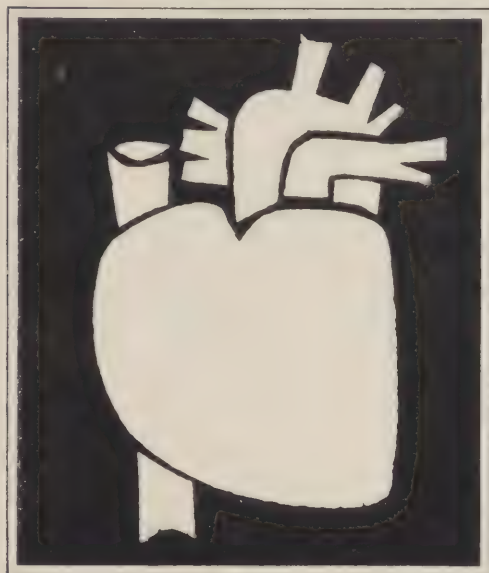


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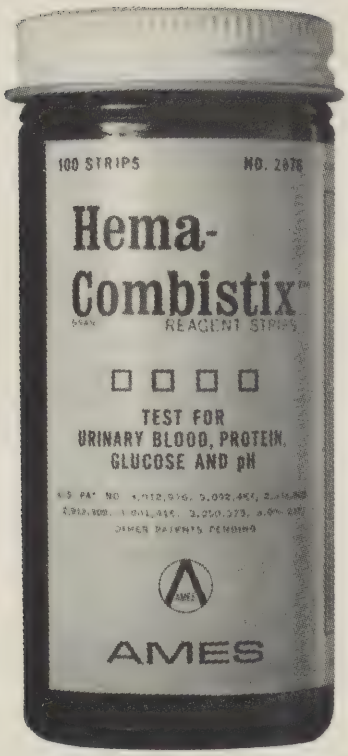
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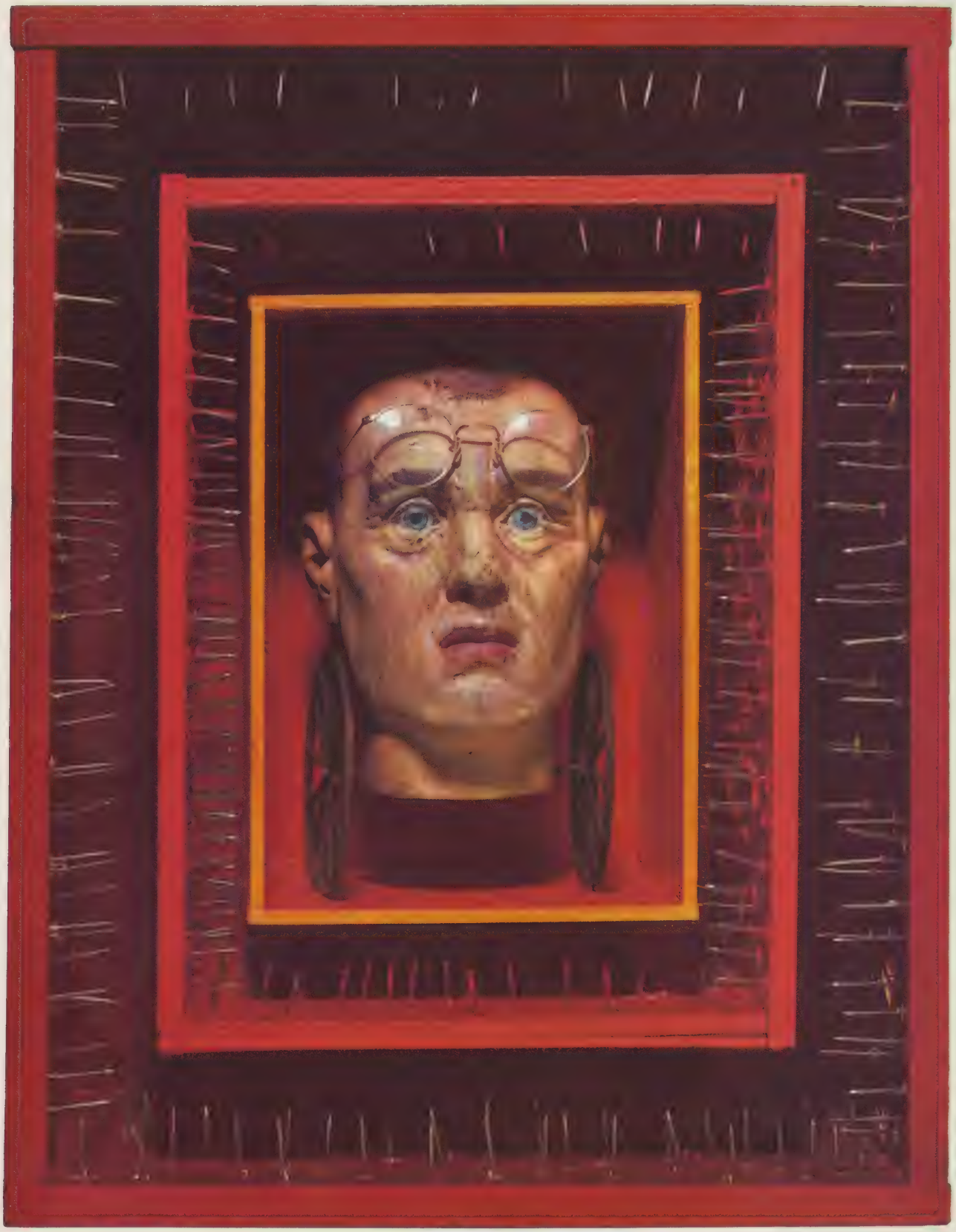
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*Clinical report on file, Medical Department, A.H. Robins Co., Inc.

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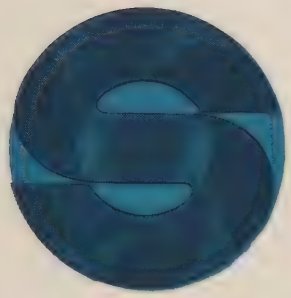
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Of 1,088 patients with confirmed skin and soft-tissue infections... 1,036 or 95.2% were treated successfully with Signemycin®

Note:
Morador et al.* obtained *excellent results in the treatment of 185 out of 191 soft-tissue infections*, all due to staphylococci. They state: "In the most serious infections occurring in patients with impaired resistance (mainly diabetics) we have had very good results in the control of the infectious condition." In these studies, incision and drainage were employed where indicated.

*Morador, J. L. et al.: Antibiot. Ann. 1959-1960:716.

Condition	No. of Patients	No. Cured with Signemycin
Abscesses, various	35	34
Abscess, gluteal or perianal	54	52
Burns, infected	331	307
Carbuncles and furuncles	125	122
Cellulitis	104	102
Lacerations and wounds, infected	142	128
Ulcers, infected	107	106
Various superficial infections	190	185
Totals	1,088	1,036 (95.2%)

consistently effective...often when others fail

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Side Effects: Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

Precautions: Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

Formulas: Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

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Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

More detailed professional information available on request.

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Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

Note:

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

Condition	No. of Patients	No. Cured with Signemycin
Ear, nose and throat infections	507	465
Respiratory infections	1,028	954
Gastrointestinal infections	425	387
Genitourinary infections	748	684
Skin and soft-tissue infections	1,088	1,036
Bone and joint infections	71	64
Deep-seated or generalized infections	257	251
Obstetrical & gynecological infections	341	320
Miscellaneous conditions	592	570
Totals	5,057	4,731 (93.5%)

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Cautions—Occasional side effects, often dose-related, are drowsiness, ataxia, minor skin rashes, menstrual irregularities, nausea and constipation. Paradoxical reactions may occasionally occur in psychiatric patients. Individual maintenance dosages should be determined. Advise patients against possibly hazardous procedures until maintenance dosage is established. Though compatible with most drugs, use care in combining with other psychotropics, particularly MAO inhibitors or phenothiazines; warn patients of possible combined effects with alcohol. Observe usual precautions in impaired renal or hepatic function, and in long-term treatment.

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Amytal is a moderately long-acting barbiturate that takes the edge off daytime anxiety and tension without significant change in mood and attitude. Since Amytal is metabolized in the liver within twenty-eight hours, overlapping of effect is minimized, and renal damage does not constitute an absolute contraindication to the drug.

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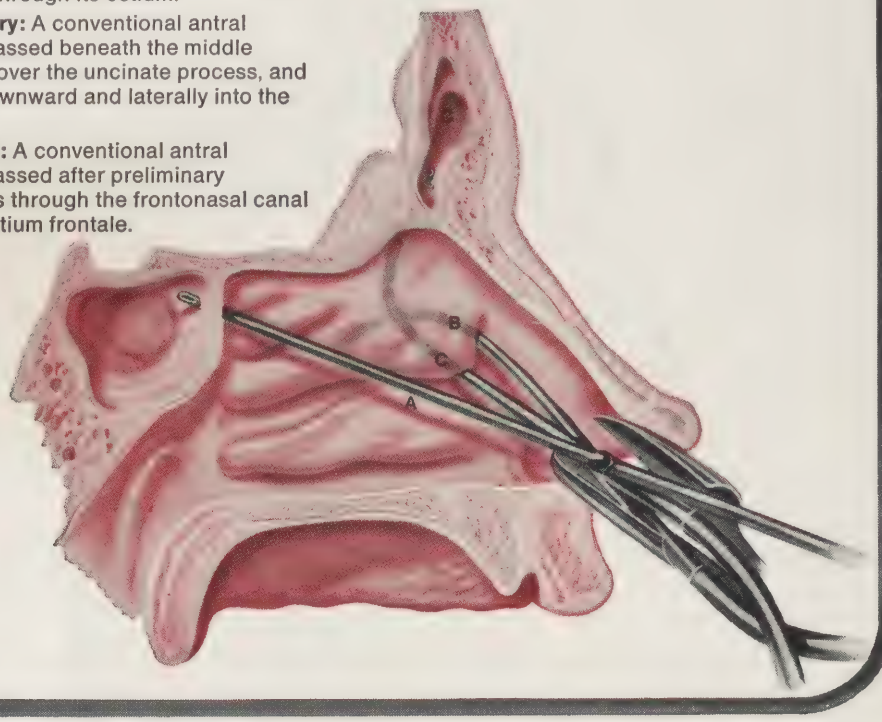
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Sagittal anatomical section of nasal cavity showing approach for probing or irrigation by cannulas.

A—Sphenoid: A sphenoid cannula (under 13.5 cm.) passed around the middle and superior turbinates to the anterior wall of the sinus through its ostium.

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*Reed, G. F.: Sinusitis, New England J. Med. 267:402, Aug. 23, 1962.

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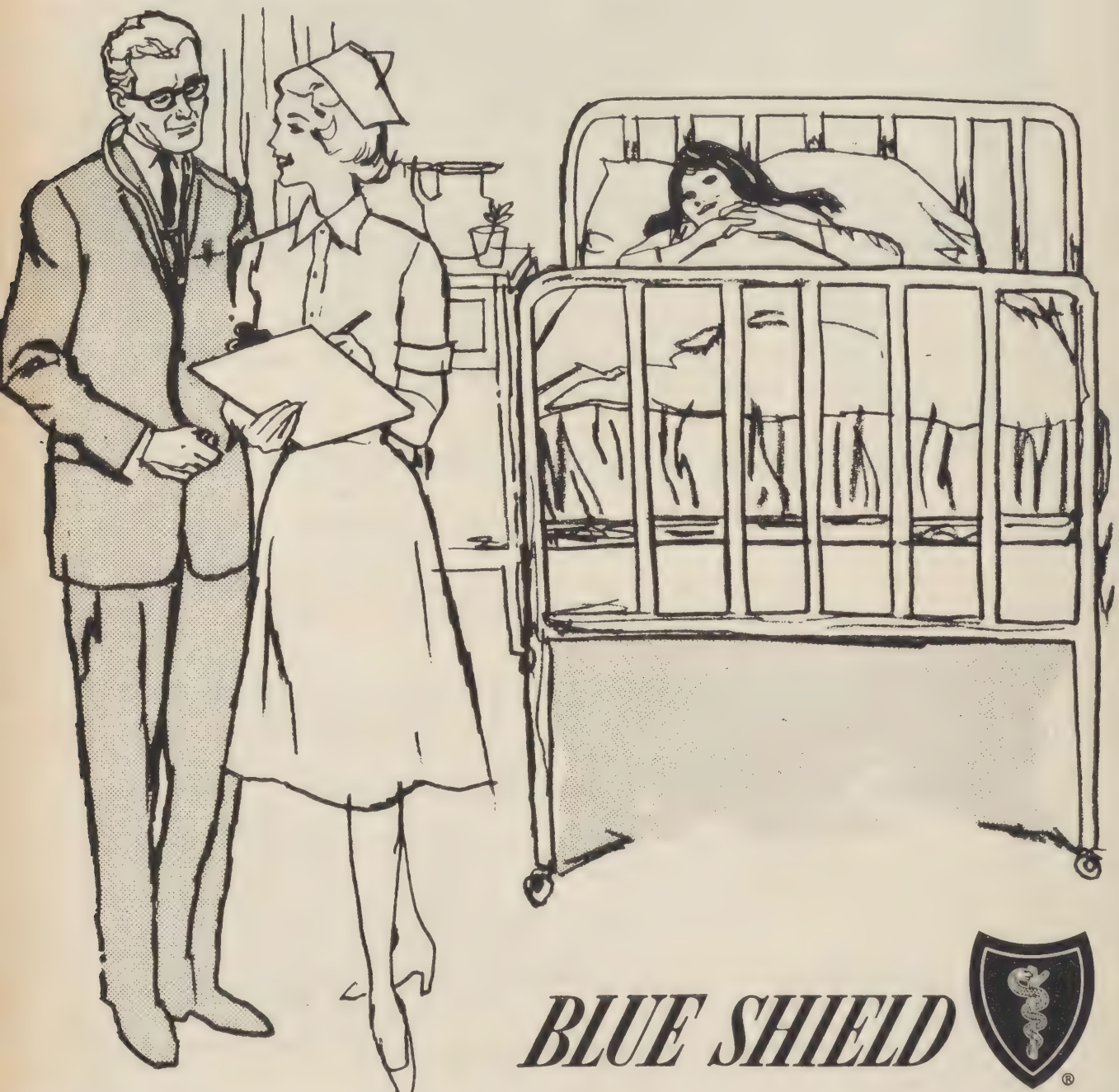
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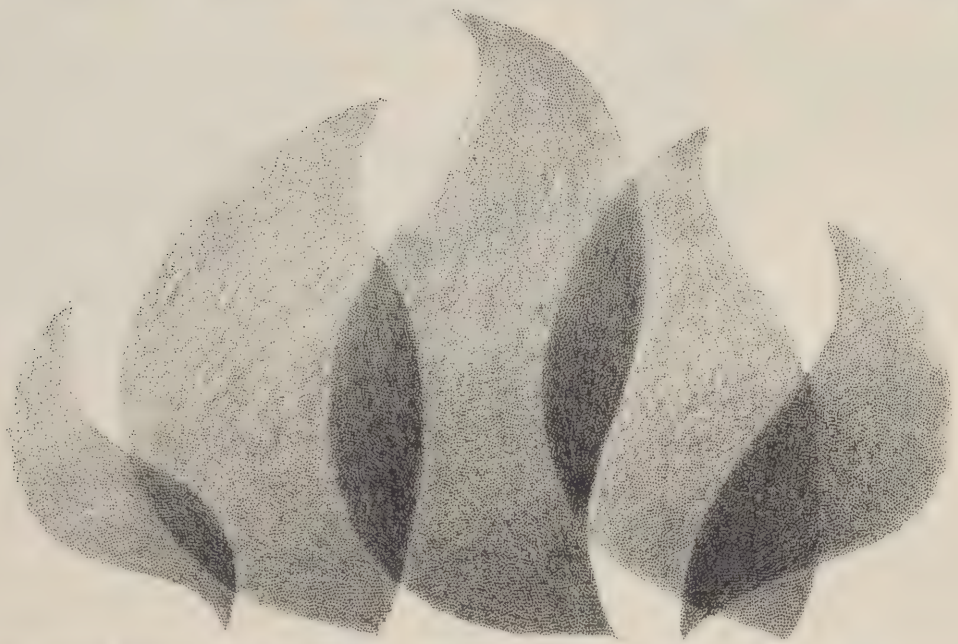
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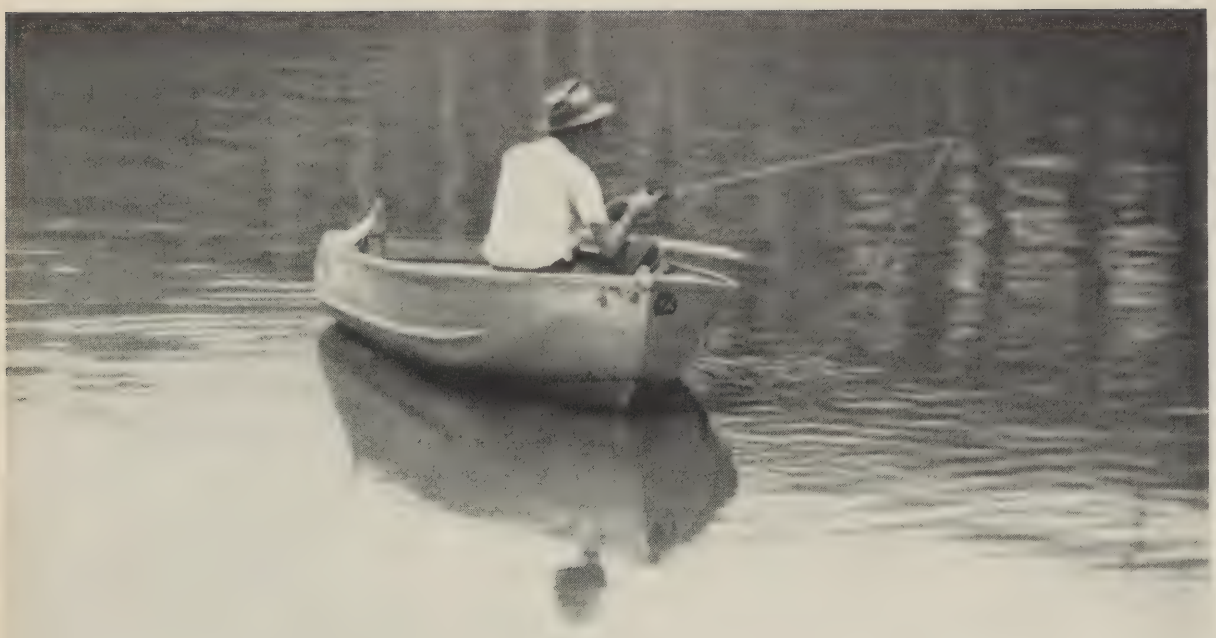
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REFERENCES: 1. Silipo, S., et al.: J.A.M.A. *177*:378 (Aug. 12) 1961. 2. Aronovitch, M., et al.: Canad. M.A.J. *85*:875 (Oct. 14) 1961. 3. Miller, W. F., et al.: J.A.M.A. *180*:905 (June 16) 1962. 4. Said, S. I., and Banerjee, C. M.: Am. J. Med. *33*:845 (Dec.) 1962. 5. Wheeldon, P. J., and Perry, A. W.: Canad. M.A.J. *89*:20 (July 6) 1963.

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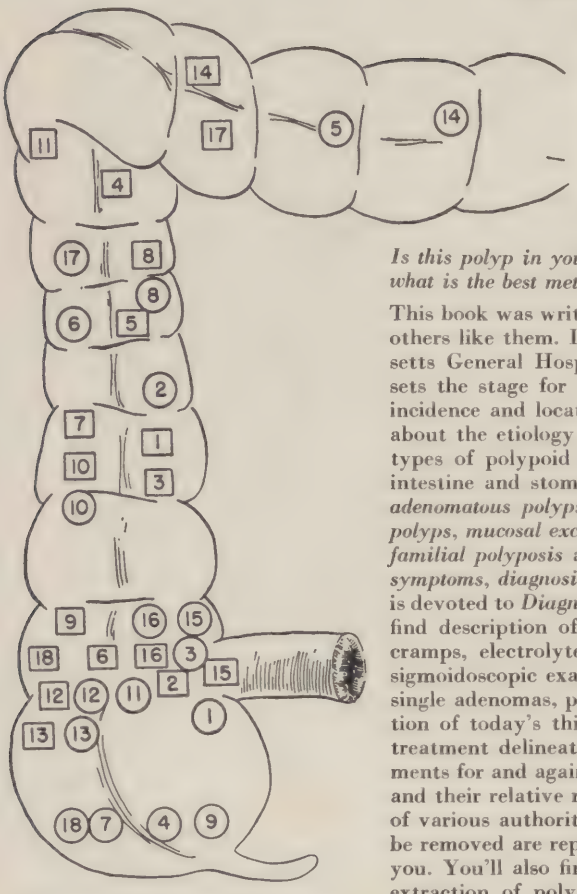


Figure 3-25. *Location of cancer and simple adenomas in resected cancers of the right colon. Squares locate cancers; circles, adenomas.*

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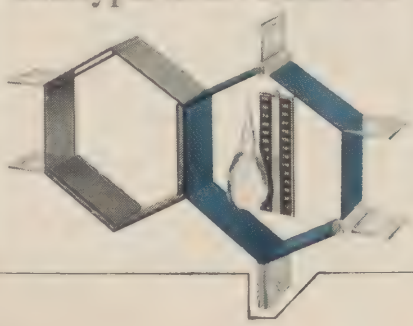
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1. Steigmann, F., and Griffin, R.: Evaluation of Quinethazone, a New Diuretic. J. Amer. Geriat. Soc. 11:945 (Oct.) 1963.

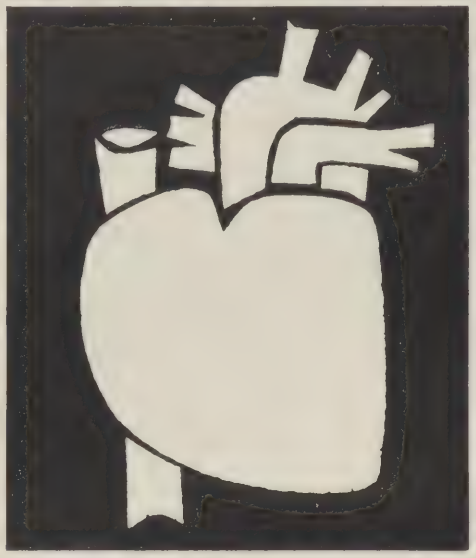
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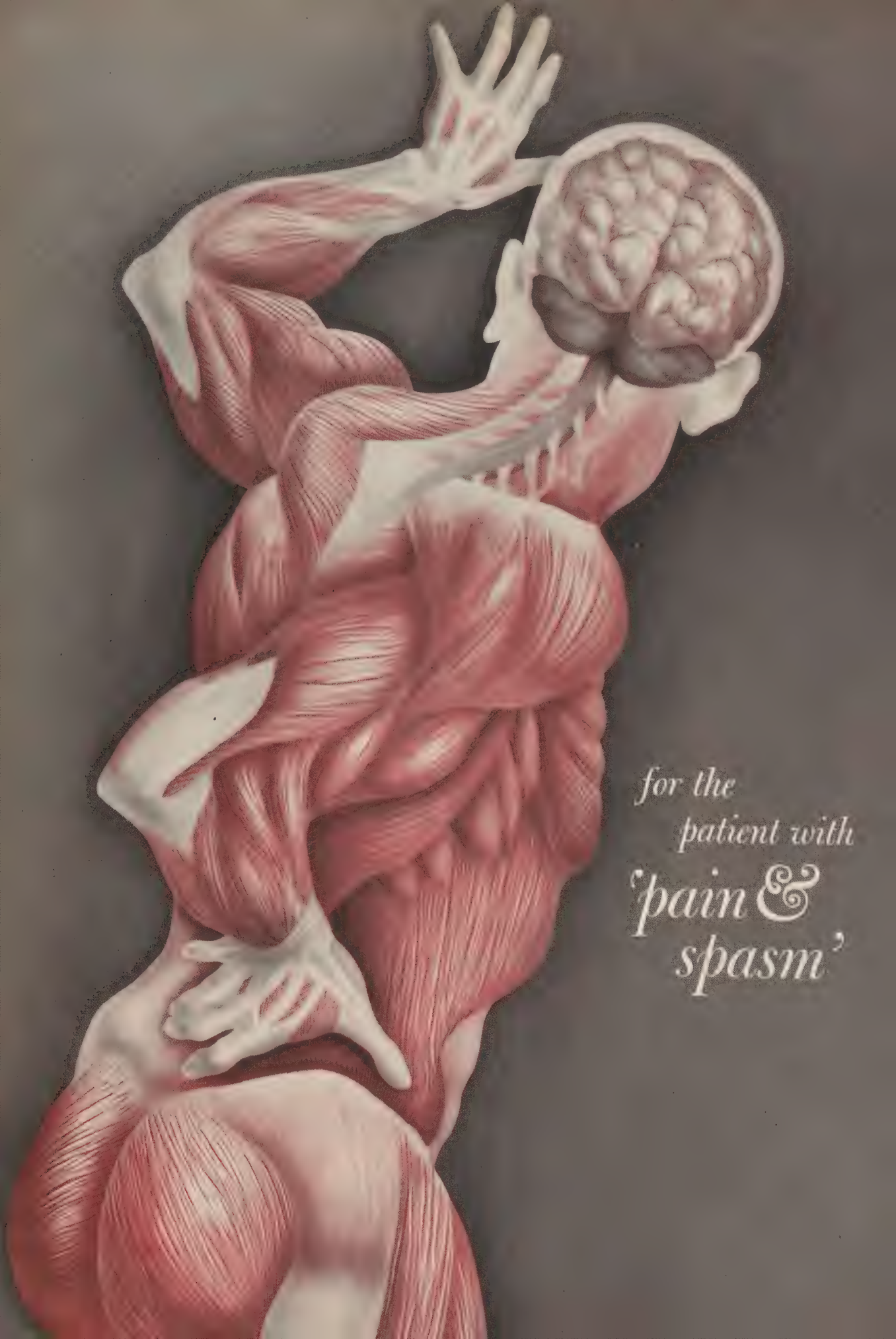
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The Journal
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VOLUME 60 December, 1964 NUMBER 12

CEREBRAL ANGINA

HIRAM B. CURRY, M. D.

Medical College of South Carolina, Charleston, S. C.

Let me assure you I am not describing a new clinical syndrome. I hope the reason for the title will become apparent in a few minutes.

The clinical syndrome of angina pectoris is well known to all physicians to denote recurrent and transient paroxysmal attacks of pain usually in the substernal area. The intermittent character and possibly grave consequence were beautifully described in the original paper by Heberden in 1772.[1] Edward Jenner first called attention to "ossification" of the coronary arteries in patients with angina pectoris. The relationship of angina pectoris to coronary artery narrowing was recognized in the late 18th century but coronary thrombosis and myocardial infarction were not clearly described until 1912 by Herrick.[2] Paul Dudley White, who graduated from medical school in 1911, states he never heard the term coronary thrombosis as a medical student, intern, or resident at the Massachusetts General Hospital or as a post-graduate student in London. He first heard the term in 1917.[3] Tremendous strides have been made in the diagnosis and treatment of coronary artery disease in the past 47 years. We now attempt to subdivide angina pectoris according to its severity into exertional angina, nocturnal angina, and preinfarction angina.

Physicians also see another group of patients who have recurrent, transient, and paroxysmal attacks — intermittent transitory focal motor and sensory deficits of cerebral origin. There are many references to such symptoms in the English, French, and German literature in the 19th century. Because these symptoms were intermittent and transitory, they were attributed to vasospasm.

In the first half of this century, considerable research was done evaluating the reactivity of the cerebral blood vessels to direct stimulation and stimulation via the cervical sympathetics. The fact that the cerebral blood vessels reacted only one-eighth as much as cutaneous vessels and vessels of many other organs did not discourage the proponents of the vasospasm theory. In 1953 Miller Fisher and Douglas Cameron reported that anticoagulants prevented the recurrence of these intermittent symptoms. They could not offer a good explanation for their observation.[4]

In the late 1940's while correlating lesions of cerebral thrombosis with clinical symptoms, Miller Fisher noted that the area of cerebral infarction usually correlated well, but very careful examination of the cerebral blood vessels supplying the infarcted area did not show

This address was presented at the South Carolina Medical Association meeting at Myrtle Beach, South Carolina, in May 1963.

occlusion or even significant stenosis in many cases.[5] It was this discrepancy that led him to study the carotid and vertebral arteries in the neck where he found occlusive or significantly stenotic atheromatous lesions in approximately one-third of the cases. With attention now focused on narrowed cervical and intracranial arteries, emphasis shifted from the vasospasm theory to that of vascular stenosis or occlusion.

The finding of significant narrowing of neck and intracranial vessels, the availability of anticoagulants for treatment, and the introduction of cerebral angiography into clinical medicine all served to excite interest and draw attention to the long neglected pre-stroke and stroke patients. A great deal has been accomplished in the past decade, and it is now possible to help some patients who in the past would have had a bleak future. The day has come when the alert physician can predict that his patient may be in danger of having a cerebral thrombosis and by practicing good medicine he may be able literally to jerk his patient back from the precipice.

By now the choice of the title "cerebral angina" should be obvious to you — if you recall that the original meaning of the word angina is to strangle. I submit to you that in the literal sense of the word the blood supply to the heart is being strangled in angina pectoris; and the blood supply to the brain is being strangled during transient ischemic attacks. The end result of this strangling for the heart is myocardial infarction; for the brain, cerebral infarction. The common denominator is ischemia — strangling causes ischemia.

Both angina pectoris and transient ischemic attacks are hemodynamic crises for their respective organs. They can be compared in many ways. On the one hand the heart responds to activity by increasing its rate and force which naturally increases its metabolic needs. When the increased circulatory demands cannot be met, the hemodynamic crisis develops which we know as angina pectoris. This is the stage of exertional angina or angina of effort. On the other hand the metabolism and circulation of the active brain remains essentially constant, not appreciably increased by exercise or deep thinking as does the heart with exercise. This means then that a hemodynamic crisis can develop earlier in the heart than in the brain and explains why there is no exact corollary for angina of effort in the brain.

The next grade of angina pectoris is nocturnal angina, a form of angina not perfectly understood. It may be due to a higher grade of arterial occlusion plus a decreased cardiac output and decreased blood pressure which occurs during sleep. Mobilization of slight edema fluid and sodium retention known to occur at night may also be contributing factors. These slight alterations in circulation are sufficient even at rest to cause a cardiac hemodynamic crisis — nocturnal angina. In the cerebral circuit we see a similar event: the transient ischemic attack usually comes on at rest and during sleep — the same mechanisms just mentioned probably cause these attacks also.

Just what are transient cerebral ischemic attacks? These can be almost any neurological abnormality of sudden onset which lasts a few minutes, subsides over a period of a few minutes and tends to be recurrent. A sudden loss of strength or the sudden onset of a peculiar sensation or numbness in an arm or leg or over half of the body are the commonest symptoms. Less often transient blindness, double vision, and depressed consciousness are symptoms. The same general area of the body is affected with each attack and in general the same symptoms are repeated time and time again. The reason for this is that the symptoms are caused by an area of ischemia in the brain; this ischemic area is supplied by a specific blood vessel whose quota of blood is temporarily reduced for one reason or another. The symptoms can vary in extent, duration and severity, but their anatomical representation is in the same area of the brain supplied by the same narrowed blood vessel. When a stenotic or occlusive lesion is in the carotid artery, or its more terminal divisions, the symptoms will usually be a motor or sensory disturbance or both in the opposite side

of the body. When the narrowed vessel is the vertebral or basilar artery, then the transient symptoms are those of brain stem ischemia: blindness, double vision, sensory changes about the face, dizziness, difficulty in talking, and even loss of strength in any or all of the extremities. A change in conscious level varying from slight sleepiness to unconsciousness is also caused by ischemia of the brain stem.

In the overwhelming majority of cases the disease underlying both angina pectoris and transient ischemic attacks is atherosclerosis. This is certainly not an intermittent process. Then how are we to explain the characteristic intermittency of the symptoms? This is best understood if we visualize a delicate balance existing between the blood supply and the metabolic needs of the heart and brain. Anything that decreases the blood flow to the organ such as a decrease in blood pressure, arrhythmia, heart failure, or an increase in blockage in the vessel will certainly upset this delicate balance. The result when the balance is upset is ischemia.

I wish to focus attention now on the atherosclerotic plaque for a moment. Though these plaques appear firm and stable, changes can occur on or in them to reduce the lumen of the blood vessel. First their surface can ulcerate and be the nidus for a layer of thrombus—this can further narrow the lumen, upset the balance I have mentioned, and cause symptoms until that balance is restored. In both the heart and the brain this is accomplished by the opening up of collateral vessels, with consequent improvement of the collateral circulation. This series of events explains the sudden onset of the symptom and the persistence of this symptom until the collateral circulation becomes adequate, at which time there is recovery of function. Bleeding under and into an atherosclerotic plaque occurs occasionally and has the same effect on this delicate balance between blood supply and metabolic needs as does the thrombosis just described.

When one sees a patient having an acute anginal attack, he cannot determine if the myocardial ischemia will persist until myocardial infarction occurs; neither can he determine if the transient cerebral ischemic attack will continue until cerebral infarction results. Both patients present an emergency and a tremendous challenge to the physician whose aim should be to increase the blood supply to the organ in distress. The coronary arteries respond quickly to nitroglycerin; but unfortunately we do not have a readily available helpful drug for the patient having a transient cerebral ischemic attack. Most vasodilators work better elsewhere than in the brain, netting an actual decrease in cerebral blood flow. Stellate ganglion blocks and CO_2 inhalation were advocated for a period but are seldom employed now.

Just as a patient who has had his first episode of angina is studied carefully by ECG, Master's test, and blood lipid determinations to prove the diagnosis, and a carefully thought-out therapeutic regimen is adopted, so should the patient who has recovered from his transient cerebral ischemic attack be investigated and treated. *The stakes are the same—the patient's future useful life.*

Transient cerebral ischemic attacks occur as a warning phenomenon in more than 80% of patients who suffer cerebral thrombosis. Thus it appears that a higher percentage of patients have ample warning before cerebral thromboses than before myocardial infarctions.

A carefully taken history will give valuable clues regarding the area of the brain in jeopardy and from this can be deduced the affected blood vessel. This is of practical importance since a lesion amenable to treatment may be discovered. If there is involvement of a carotid artery, then often the carotid pulsation is reduced or absent. If the vessel is stenotic but not completely occluded a bruit over the neck will probably be heard. The central retinal artery pressure can be determined easily by ophthalmodynamometry to confirm such a lesion. If the narrowed area is at the origin of the vertebral artery, then a bruit may be heard in the supraclavicular fossa. It is evident then, that an anatomical diagnosis can be made in many cases by careful bedside examination. Arteriography of the

vessel is necessary to confirm an operative lesion.

Even in those cases where careful examination of the neck does not reveal any abnormality and the arteriogram is normal, the history of transient recurrent episodes of neurological abnormality of sudden onset, lasting a few minutes, and clearing in a few minutes is characteristic enough to be recognized as transient cerebral ischemic attacks. We must remember that small cerebral vessels usually cannot be visualized by arteriography. Narrowing of these can produce the same pattern of symptoms. These small vessels are frequently the site of atheromatous narrowing in hypertensives and diabetics.

All of you are aware of the lack of agreement about the use of anticoagulants in the treatment of angina pectoris even in nocturnal and preinfarction angina. The controversy about their use in cerebral vascular insufficiency is even greater. In a large national controlled study in which anticoagulants were used it was reported that the overall mortality rate for cerebral thrombosis was not affected by anticoagulants; the rate of thrombosis was reduced only slightly but the number of transient cerebral ischemic attacks was markedly reduced.[6, 7] The truth is that no one really knows whether or not anticoagulants are really effective in the treatment of coronary or cerebrovascular insufficiency. We clearly need more and better studies. Certainly anticoagulants cannot help the patient who has a completed stroke — in fact they are contraindicated since then they can do very real harm, yet can do no good. My experience is limited but in selected cases of patients having transient cerebral ischemic attacks I favor the use of anticoagulants, hoping the physical characteristics of the blood will be changed favorably during the period when the balance between blood supply and metabolic need is so delicate. After a few months collateral circulation should be improved and anticoagulants are discontinued. If symptoms return, anticoagulants are re-instituted immediately for an additional period. I do not plan to keep my patients on anticoagulants indefinitely for while one is taking anticoagulants there is an ever present danger of intracerebral hemorrhage and other complications.

Before answering more directly who should have surgery and who should have anticoagulants, let me remind you that atherosclerosis is a generalized and progressive disease. When this disease process becomes severe enough at any one point, when narrowing of a specific artery reaches a certain degree, then symptoms develop. Both anticoagulants and surgery are directed not at the underlying generalized disease but at the local problem of a narrowed vessel. Surgery removes the narrowed area; anticoagulants discourage thrombus formation on the atheromatous area and perhaps alter the physical characteristics of the blood, making better collateral circulation possible.

It should be said that if surgery is being considered then at least both carotid circulations must be visualized by angiography and a stenotic lesion which fits with the symptoms must be demonstrated and be accessible to the surgeon; and it goes without saying that this type of surgery requires an experienced vascular surgeon. With this information in hand a plan of attack on the diseased area can be made. In general, vessels which have been completely occluded more than one or two days cannot be helped by surgery. When the neurological event has occurred only a few hours before, there is a good possibility of re-establishing circulation. Of course, if the neurological deficit has lasted for many hours, we must assume cerebral infarction has occurred; the stroke is completed, and surgery would be useless. Contraindications for surgery in such patients are those which preclude general anesthesia.

There are some requirements for choosing anticoagulant therapy. First of all you must be convinced that the patient will follow your instructions and have the necessary laboratory studies for regulation of his medication. You must have available to you a reliable laboratory. The patient should have a telephone. Patients with a peptic ulcer history probably should not be given anticoagulants. Alcoholics

should not be given anticoagulants. We cannot be too careful in selecting our patients for anticoagulant therapy; there is room for doubt that they are really and truly helpful; there is no doubt but that they can be harmful. In order "to above all, do no harm" we must select and manage these patients with utmost care.

When can anticoagulants be helpful? In the patient who has transient cerebral ischemic attacks the number, duration, and severity are appreciably reduced and, in my opinion, the likelihood of developing a cerebral thrombosis is somewhat lessened.

During an ischemic attack prompt anticoagulation utilizing intravenous heparin may assist collateral circulation by changing the character of the blood and terminate an episode—but the physician must be absolutely sure he is not dealing with intracranial bleeding before giving intravenous heparin. The spinal fluid must be examined and be free of blood before heparin is given. I usually give 100 mg aqueous heparin intravenously, followed by 100 mg aqueous heparin into the abdominal fat every 12 hours keeping the Lee-White clotting time at more than double the control value. In most cases an oral anticoagulant (Coumadin) is begun at the time of the intravenous heparin, and heparin is discontinued when the prothrombin activity has been regulated at 20% (± 5%) activity. I have stressed surgery or anticoagulant therapy but we should not forget that an underlying anemia, heart failure, cardiac arrhythmia, febrile illness, etc. will aggravate these symptoms. In patients having a very elevated serum lipid, a special diet or drugs may be indicated. Thrombolytic agents are now being employed on a research basis but too little is known about this form of therapy for general clinical use at this time.

Just as one is concerned about extension of myocardial infarction in the early period, one should be concerned about extension of a cerebral infarction. To prevent extension is one reason for giving anticoagulants to both the heart and the stroke patient. In the early stroke patient, in the so-called thrombosis-in-evolution (changing period), there is some evidence to justify the use of anticoagulants. Of course after the infarction is completed, or after a few days when extension is very unlikely, anticoagulants can scarcely help the patient. If they are given they have the real possibility of causing serious complications without the possibility of helping the patient.

I hope I have convinced you that you should be as concerned about the future of the patient having transient loss of strength and transient abnormal sensations (and other transient neurological symptoms) as you are now for the patient having angina pectoris. The day is past when these patients are told not to worry, that they have only spasm of a vessel. They should be promptly and carefully studied, for many such patients can be helped. Coronary artery disease kills more people than any other disease; but cerebrovascular disease is first in causing misery—unhappy and unproductive lives. Nowhere in medicine is preventive medicine and early treatment so important. I look upon it as an urgent challenge—do something for that patient with cerebral strangling or cerebral angina!

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USE OF ALKALOIDS OF *VINCA ROSEA* IN ACUTE LEUKEMIA

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A current study on the control of malignant blood diseases with colchicines[25] suggests a review of the results of treating the acute leukemias with different alkaloids from *Vinca rosea*. The alkaloids of the periwinkle are receiving much more attention in the current literature than the longer used colchicines.

Acute Lymphocytic Leukemia

In the first of three clinical reports Mathe and associates[20] recorded six complete and two partial remissions in 28 patients with acute lymphocytic leukemia who were administered leurocristine; in a second and third report[21, 23] they tabulated six complete and three partial remissions in 25 patients, with some response in seven others; seven remissions and eight failures were in those under 20 years of age, while in persons over 20 there were two remissions and eight failures; peripheral lymphoblasts disappeared in nine of 25 patients and in the bone marrow of six of 25 cases; the improvement was for only a few weeks, and the alkaloid induced some digestive, neurological and hematologic side effects. Mathe[22] also observed that a patient who was resistant to prednisone and vincristine did have a partial response following treatment with cyclophosphamide. Karon[16] noted five complete and three partial remissions in 13 children given leurocristine sulfate; this was in contrast to only one remission in 29 patients who received vinblastine. Rohn and Hodes[24] secured a partial hematologic remission in one of five patients with leurocristine; they described mild gastro-intestinal tract toxicity and moderate to severe white blood cell depression. Selawry and Delta[26] chronicled partial hematologic remissions in four out of five children placed on leurocristine; toxicity included leukopenia and neurotoxicity; with vinblastine Selawry and Hananian[27] described six complete remissions and two partial remissions in nine children, and three of the complete remissions lasted more than 147 days; vincristine in combination with prednisone gave a complete remission in another patient. Hill and Loeb[10] employed vinblastine in eight children to obtain one complete and three moderate responses, while Wright *et al*[34] noted one objective improvement in four patients whose treatment with this alkaloid could be evaluated; they listed few side effects. Warwick *et al*[30] failed to note any benefit in one patient given vinblastine. George and James[7] used vincristine to induce partial or complete remissions in four of six children; they found some leukopenia. Whitelaw *et al*[32] found no improvement in a patient following the use of vincristine. Hodes *et al*[12] described a partial remission in one of two children with acute lymphatic leukemia who received vincaleukoblastine.

Acute Granulocytic Leukemia

Hill and Loeb[10] treated eight adults with acute granulocytic leukemia with vinblastine and recorded four moderate and three slight improvements, while in eight children they tabulated one marked benefit and three moderate benefits. Wright *et al*[34] observed only one objective improvement in three patients whose treatments could be evaluated. Warwick *et al*[30] reported failure of vinblastine to effect any change in seven patients, and Arm-

strong *et al*[1] noted no benefit in a child with subacute myelocytic leukemia with this drug. Hodes *et al* have released three studies on the action of vincaleukoblastine on acute myeloid leukemia: in one[11] they described some remission in two patients; in a second release[12] they noted marked improvement in both patients administered the alkaloid, and in a third paper[15] they had three patients in the blastic form of chronic myeloid leukemia fail to respond to the therapy; they described the toxicity as localized chiefly in the gastro-intestinal tract. Witte[33] reported a fair response in one patient given vincaleukoblastine, but Frost *et al*[9] observed little benefit in two patients. George and James induced partial or complete remissions in three of four children who received vincristine; some leukopenia was noted. Selawry and Hananian[27] used this alkaloid to improve the condition in one of two children, and Darby[3] employed vincristine to induce an excellent remission in a child who was resistant to prednisone, 6-mercaptopurine and methotrexate; the child was in remission at the time of reporting. Three adults with acute myelocytic leukemia failed to respond to leurocristine in a report by Karon.[16]

Acute Monocytic Leukemia

Four studies of Hodes and associates constitute an important contribution to the action of vincaleukoblastine on the control of acute monocytic leukemia. In one report[11] they treated 15 patients and recorded brief clinical and hematologic remissions but with few details; a second study[12] revealed decreases in white blood cells in all 12 patients, and five remissions; a year later[13] they described two partial remissions of four and five months in four children, and some improvement in one of three adults; finally these investigators reported two complete remissions for four and 8.5 months, and six partial remissions for 1, 2, 2, 3, 4, and 9 months in 19 patients. Mathe *et al*[20] recorded the mediocre effect of the alkaloid in several cases, and Ghrist[8] reported a brief, partial remission in a patient treated with the combination vincaleukoblastine and 6-MP. Armstrong *et al*[1] employed vinblastine to induce a complete remission in an elderly man for 2½ months, and partial remissions in two children for three and four months. Hodes *et al*[14] described a complete clinical and hematologic remission for several months in a patient with Naegeli type of monocytic leukemia, and Bond *et al*[2] secured a remission in a patient with monocytic leukemia. Neither Rohn and Hodes[24] nor Hellman and Mauro[9] could detect improvement after administration of leurocristine; the former treated six patients and the latter, one; mild gastro-intestinal tract toxicity and reversible leukopenia were observed.

Acute Stem-Cell Leukemia

Evans *et al*[5] reported on 52 children with acute stem-cell leukemia who were treated adequately with vincristine: 11 of 13 children had clinical remissions for a mean of 57 days when the drug was discontinued after complete remissions, and 125 days when it was continued every two weeks in cases not previously treated with any drug; in a previously treated group, 12 of 21 achieved bone marrow remission for a mean of 55 days when the therapy was discontinued, and 60 days when it was continued; there was some toxicity in 52% of the children but it was controlled. Darby[3] induced an excellent remission in a child for several months who was resistant to steroids, 6-MP, Mtx., and cyclophosphamide. Warwick *et al*[30] described objective remissions in four of nine patients given vinblastine.

Acute Erythroleukemia

Bond *et al*[2] indicated a hematologic response in a boy with acute erythroleukemia who received vinblastine. Hodes *et al*[15] observed no response in a patient following the use of vincaleukoblastine.

Undifferentiated Acute Leukemia

Whitelaw and Teasdale[31] treated 10 cases of undifferentiated leukemia with vincaleukoblastine and reported four remissions; one of these had the drug combined with 6-MP and experienced a remission of six weeks; the other enjoyed a 10 months remission; these investigators recorded three remissions of 1½, 7 and 7 months in eight patients who had no

previous therapy. Keiser *et al*[19] tabulated two complete remissions and one poor response in six patients on vincaleukoblastine, and Warwick *et al*[20] recounted two patients with partial remissions for four and six weeks out of five treated. Karon *et al*[17] reported nine complete remissions in 13 children who received vincristine, two of these had steroids also; the improvement lasted 94+ days; they judged the alkaloid to be of the same order of activity as 6-MP or Mtx., and possibly as active as steroids; neurological complications were noted but none was serious enough to stop treatments. The next year Karon[18] evaluated 150 cases of children and adults who were placed on vincristine: he estimated that 60% of those under 20 years of age had complete marrow remissions, but that adults responded poorly; neurotoxicity was seen in 30% of the patients. Tan and Aduna[28] described a partial hematologic remission in a child given leurocristine.

Discussion

The overall remission rate of 45% in 325 patients with acute leukemias who were given alkaloids of *Vinca rosea* is lower than the 52% in 77 patients receiving colchicine alkaloids.[25] Patients with acute stem-cell leukemia showed the highest remission rate of 64% in 44 patients who received the periwinkle alkaloids, while those with acute lymphocytic leukemia registered only a 36% rate in 138 patients; the report of Karon[16] of only one remission in 29 cases pulled down the remission rate from 46% in 109 cases of acute lymphatic leukemia. Cases of undifferentiated acute leukemia registered a 52% rate in 43 patients, while acute monocytic cases rated 43% in 51, and acute granulocytic rated 46% in 47 patients. The few trials on combination of alkaloids with other drugs revealed no striking results. Some differences are noted in the effect of different alkaloids on the several types of acute leukemia, but the number of patients is too limited for any conclusions.

Acknowledgments. The original literature was made available by the National Library of Medicine and the libraries of Furman University and Greenville General Hospital. Financial support has been received from the Research Corporation.

A list of references may be obtained from the author.

Capacitance Pickups for Cardiovascular Sounds. D. Groom, Y. T. Sihvonen & W. W. Francis. (Charleston) Exp Med Surg 22:130-139, 1964.

The sensitivity and versatility of the human ear with the stethoscope are not easily equalled by electronic methods of auscultation. Major problems entailed in recording cardiovascular sounds near the intensity threshold of audibility are the very wide range of amplitudes present at the chest wall, sufficient coupling of vibrational energy from a medium of high density to the transducer with attenuation of unwanted frequencies, and adequate signal-to-noise ratio.

A non-acoustical capacitance pickup is described which, when used in a soundproof room, is capable of reproducing heart murmurs of extremely low intensity. All of 71 normal subjects were demonstrated to have systolic murmurs composed of frequencies in the audible range.

The mechanism and site of origin of these systolic sounds in the adult is uncertain. However, their presence is understandable on the basis of what is known of circulatory dynamics, and it appears that they represent a universal functional murmur which is usually subaudible.

Augmentation of the Audibility of Fetal Heart Sounds by Frequency Multiplication. D. Groom, Y. T. Sihvonen, Anne Bass, W. W. Francis (Charleston) Amer J Obstet Gynec 90:345-349, Oct. 1, 1964.

Audibility of fetal heart sounds reproduced from the maternal abdomen can be enhanced many-fold by frequency multiplication in accordance with the Fletcher-Munson characteristic of human hearing.

Utilizing a capacitance pickup and filter system tuned to 40-60 c.p.s., and a simple frequency quadrupling circuit, these sounds — predominantly of low frequency energy, can be reproduced loudly without feedback for continuous monitoring of the fetal heart rate and rhythm.

BRANCHED-CHAIN FATTY ACID ESTERS AS SKIN PROTECTIVE-THERAPEUTIC AGENTS (SILICONE-FREE)

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One of the major problems encountered by the dermatologist is the management of domestic or industrial dermatitis.[1] Various modalities such as steroid or tar therapy may clear the symptomatology rapidly, but it is often impossible for patients such as dentists, housewives, beauticians, dishwashers, etc., to avoid further contact with the provoking agents. Upon re-exposure to irritating soaps, detergents, soluble cutting oils or other water soluble sensitizers, the recurrence of the dermatitis is apparently unavoidable. It has been observed that eczematous exacerbations of the hands have a tendency to occur much faster and more frequently in winter than in summer.[2]

This study pertains to the use of branched-chain fatty acid esters combined with hydrocortisone and other medicinals in a water in oil cream. This formulation is non-greasy and proved quite valuable as both a protective and therapeutic agent in detergent dermatitis, atopic eczema and in various dermatoses such as xeroderma (farmer's and sailor's skin), neurodermatitis, seborrheic dermatitis, dyshidrosis, pustular psoriasis and hypostatic eczema.

Silicones, nitrocellulose, synthetic waxes, lanolin and similar substances are often present in barrier creams. While these offer some protection they also possess certain undesirable characteristics. They are extremely occlusive and often irritating to inflamed epidermis. They leave a greasy and oily layer on the hands which meticulous individuals often find objectionable. If silicone creams are accidently rubbed into the eyes, their removal is quite difficult. In addition, some pain and transitory conjunctivitis may ensue.[3] Silicones may delay the healing processes of cracked and fissured skin. Dyshidrosis as a primary or associated entity contraindicates the use of a silicone cream.[4]

Materials and Methods

Lanolin (wool fat) is a familiar example of a group of substances referred to as branched-chain fatty acid esters. A recent addition to this series is natural preen gland oil secreted by ducks, swans and other aquatic fowl. An equivalent material has been synthesized recently and found to possess unique and advantageous characteristics as a protective and therapeutic agent to damaged skin.

One of the substances most impervious to the penetration of water is the coating of preen gland oil applied by ducks to their feathers and bodies. Deficiencies or absence of this secretion causes damage to plumage, which may include discoloration, roughness and shedding. Interference with maintenance of normal body temperature and swimming function have also been observed. Preen gland oil is remarkably similar to human sebum, having in common the presence of fatty acids of medium carbon numbers between C_6 and C_9. Since reduced concentrations of sebum are generally characteristic of dry, scaling, fissured and chapped skin, it seemed logical to substitute a substance of this nature which in addition possesses amazing water repellent properties.

A water-in-oil emulsion was manufactured, containing synthetic preen gland oil in the

outer phase. Also incorporated were four medicaments each of which provides desirable therapy in dermatoses of the hands. This cream contains 0.5% hydrocortisone alcohol for its acknowledged anti-inflammatory, soothing anti-eczematous action,[5] allantoin 0.25% for its well known keratolytic and healing properties,[6] and hexachlorophene and parachlorometaxylenol for their effective and synergistic antibacterial and antifungal activity.[7, 8]

This preen gland oil cream[9] in clinical evaluation demonstrated unique, environmental skin protection, exhibiting the barrier type qualities of the silicones but being devoid of their objectionable characteristics. It combines beneficial medicinal treatment for damaged epidermis with adequate protective capacity.

Upon application to the hands, rapid cessation of further fissuring and drying is observed. This impervious multi-purpose cream appears ideally suited to achieve rapid recovery for individuals predisposed to dermatitis of this type. Continued use acts as an excellent deterrent to recurrences.

Tenda-HC Cream yields distinctive results in the subacute and chronic phases. Whenever erythema, roughness of texture, defatting, cracking, scaling, fissuring, lichenification and accompanying discomfort is present, this cream is not totally occlusive. However, the acute, weeping, eczematous processes should be completely cleared prior to instituting this therapy.

Typical Case Histories

The following cases are examples of the excellence of this preparation:

1. J.M., 20 yr. old, white male, soda fountain clerk, complained of chronic vesicular eruption of hands with secondary infection for past 9 months. Wet dressings were applied, followed by constant use of Tenda-HC. Condition cleared promptly. Patient has continued working and hands remain clear with continued use of Tenda-HC.
2. V.H., 52 yr. old, white female, housewife and beautician, complained of chronic eczematous eruption of fingers. She had numerous contacts with cosmetics, preparation of vegetables in cooking, etc. Hands cleared rapidly with Tenda-HC. Now she uses the protective cream and hands have remained clear.
3. R.B.J., 63 yr. old, farmer's housewife. She has had eczematized dermatitis of hands and forearms which she attributed to milking cows, off and on for the past 12 years. Within three weeks, dermatitis was cleared and remained clear even though she continues her daily chores.
4. W.R.V., 40 yr. old, white male. He has had eczematous eruption of hands, forearms, and face for the past six years due to cutting oils used in grinding lenses. These oils showed positive patch tests four years ago with eruptions so severe as to cause temporary discontinuation of work. His dermatosis cleared with Tenda-HC Cream and he has been able to work continuously. Despite exposure, his hands remain completely free of flare-ups with continued use of this agent.
5. D.M.C., 7 months, white female, had typical "diaper rash" of 4 weeks duration. Condition cleared promptly and completely within 1 week and has remained clear with use of Tenda-HC daily.

Table 1 is a tabulation indicating the results obtained in 153 cases with this cream.

Table 1
CLINICAL RESULTS WITH TENDA-HC CREAM

Diagnosis	Cases	Results			
		Excellent	Good	Fair	Poor
Housewives eczema (includes contact dermatitis)	60	24	34	2	0
Atopic eczema	19	5	13	1	
Intertrigo	12	8	4		
Xeroderma (Farmer's and sailor's skin)	17	5	12		
Neurodermatitis	8	1	6	1	
Seborrheic dermatitis	14	2	10	2	
Dyshidrosis	4	2	2		
Pustular psoriasis	14	2	9	3	
Hypostatic eczema	5	4			1
	153				

Discussion

This "wet work" protective cream is therapeutic in small amounts and elegant in appearance. The excellent skin protectant action, in combination with its healing, antiseptic properties, makes Tenda-HC Cream a valuable preparation for the curtailment of inflammation, irritation, pruritus and similar manifestations in eczematoid, atopic, contact, and stasis dermatitis in all stages of advancement, regardless of duration.

This cream, while very useful in the man-

agement of various dermatoses, is not without an occasional failure. The development of this product should stimulate, not stop, the quest for additional inert, non-sensitizing and non-irritant repellent protective devices. The frequently disfiguring and disabling skin diseases associated with prolonged exposure to soaps, detergents, water, chemicals and allergens demand further experimentation and investigation to produce superior protective and therapeutic measures.

Summary

A new cream has been developed, formulated with preen gland oil, anti-inflammatory and antiseptic ingredients. Although there is no silicone present, this cream demonstrates unusual water, soap and detergent repellent properties. It has proven particularly useful in the management of various skin conditions where erythema, cracking, scaling, fissuring and lichenification present a problem.

It provides the protective qualities of silicones, but preen gland oil appears to be actually beneficial and not irritating to the skin.

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Amyloid Heart Disease. A. Farrokh, T. J. Walsh, and E. Massie (Heart Station, Barnes Hosp, St. Louis) Amer J Cardiol 13:750 (June) 1964.

Cardiac amyloidosis is a disease of obscure etiology that affects older persons. Its only symptom, congestive heart failure, does not respond to treatment and eventually proves fatal. Nonspecific electrocardiographic findings have in the past curtailed antemortem diagnosis, but recent advances in electrocardiography have made possible the discovery of features typical of this disease. Twenty-eight cases are presented, and their clinical, electrocardiographic, and vectorcardiographic findings are reported. These elderly patients with congestive heart failure, without a history of heart disease, all exhibited the following combination of electrocardiographic patterns: left axis deviation of QRS, low QRS voltage in the limb leads, a Q-S configuration and/or small R waves in V_1 to V_3, and a VF with or without atrial fibrillation, and rapid ventricular response. Autopsy results confirmed all diagnoses: the heart was large in 23 cases, and microscopic examination revealed amyloid deposition in myocardium, interstitial tissue and blood vessels.

Comparative Efficiency of Stethoscopes. Dale Groom, M. D. (Charleston) Amer Heart J. 68:220-226, Aug. 1964.

Comparisons of stethoscopes disclosed surprisingly large differences in the efficiency of transmission of cardiovascular sounds. Chief determinants of efficiency are the length of the transmission pathway, its total enclosed volume, the internal diameter and the physical characteristics of the tubing, and especially the integrity of the acoustical seal between the auditory canal and the chest wall. Even minimal leaks around ill-fitting earpieces, in the tubing, in the changeover valve, or in the chestpiece not only admit ambient noise into the enclosed acoustical system but grossly impair the transmission of sounds.

Measurements of stethoscopic audibility of murmurs demonstrate that the efficiency of the average stethoscope in use can be materially increased, and that a reduction in the levels of ambient noise commonly encountered in wards and examining rooms results in a significant improvement in auscultatory proficiency.



President's Page

HOSPITAL PERSONNEL SHORTAGE

While we are concerned about the medical care for our expanding population, the South Carolina Hospital Association is taking definitive action to remedy the deficit in necessary hospital personnel.

Our hospitals in South Carolina, excluding federal institutions, have 98 employees per 100 patients while the national average is 128 employees per 100 patients. In South Carolina the ratio has decreased in the last few years, and over the nation it has increased.

Hospital beds in South Carolina have increased rapidly in recent year. In spite of that, in 1962 this state met only 65.85% of the needed general Hospital beds. Personnel to man these hospitals are scarce. According to a publication by the South Carolina Hospital Association, the following are among the present shortages:

49 hospitals have no physical therapist (RPT)
67 hospitals have no occupational therapist (OTR)
47 hospitals have no pharmacist (R.Ph.)
67 hospitals have no social worker (NASW)
19 hospitals have no medical record librarian (RRL)
48 hospitals have no dietitian
22 hospitals have no registered X-Ray Technician (RXRT)
45 hospitals have no registered Medical Technologist (ASCP)
49 hospitals have no EKG technician

In an attempt to do something about this and meet this hospital personnel need, the South Carolina Hospital Association from its headquarters in Columbia is launching a special project entitled "A comprehensive program for Health Education Recruitment." They have added to their present efficient staff, a full time director of this project. Duke Foundation has extended a grant to insure the beginning of the operation of this project and indicate continuing help. We offer our cooperation to the South Carolina Hospital Association in this ambitious undertaking.

FRANK C. OWENS, M. D.

Editorials

Our Wellmeaning Friends

Recently in one of our newspaper columns this item appeared:

"So the Russians sent a doctor sky-high by putting him into a rocket ship. So what? I recently got the same result by asking one to make a house call."

A mild query to the columnist as to whether he might not have the wrong kind of doctor elicited a kindly reply:

"Just kiddin', Doc, just kiddin'. You know I love you guys."

But this does not erase the impression of the public that housecalls are now taboo in certain circles—or is the man right?

The Pressure Is On Again

The Johnson administration has placed so-called medicare at the top of its legislative program for 1965.

President Johnson has said:

"First we must provide adequate hospital and nursing home care for our senior citizens by a sound program financed through contributory social insurance. I pledge that the legislation to accomplish this will head my program next year."

Administration forces in Congress expressed confidence that most of Johnson's legislative program would be approved next year in light of the Democratic victory in the elections.

The Administration was reported to be considering a program that would be financed by a separate employer-employee tax rather than an increase in the social security tax as called for in legislation that died in a House-Senate conference committee when Congress adjourned in October.

There should be no relaxation in our opposition.

Vaccine Sniffing

Word comes to us that there may soon be a way out of the undesirable process of administering vaccines and antibiotics by the needle. An exponent of the method of giving these substances by inhalation of aerosol sprays points out that the technique gives the same benefits as injections, perhaps even better results than some injections and certainly much better effect than does oral administration. We can picture the cringing child of today replaced by the contented child of the future happily inhaling the spray from an aerosol can or bottle. Since some children of our acquaintance resent any kind of interference with their personal dignity, we can imagine a few recalcitrants who will no more breathe a spray than they will stand for a needle, but after all, there is always the old needle in reserve for the resolute fighter.

In Vino Aequanimitas

Those of us who have observed our friends or others in the grasp of alcohol have probably long been aware that certain forms of alcoholic drinks tend to affect the drinker in different ways. Now a study of the brain wave patterns set up by wine indicates that this beverage has a tranquilizing effect and contributes to the sense of well-being while those patterns produced by a dry martini show that this more vigorous drink allays anxiety and dulls reaction to stress. If one is determined to seek these comforting effects through the means of alcohol, he can make his pick. If he is an amateur psychologist, perhaps he can determine what prescription of wine or gin is suited for his particular problem. Or perhaps the seeker of surcease should apply to his psychiatrist for analysis before setting out freehanded on the consumption of alcohol.

Perhaps it comes down partly to a question of quantity. The pleasant effects of wine and its medicinal value are well known, while the potentially dangerous effects of the repeated martini are also recognized. Experiments to show these differences were conducted recently on twenty willing, healthy young men,

and electroencephalographic readings gave figures which were suggestive but by no means conclusive. These experiments remind us of the time when our physiology professor called for volunteers from the class to test the effect of alcohol on blood pressure. As we recall, not a man wavered in his determination to further the cause of scientific knowledge.

A MERRY CHRISTMAS

The **Journal** wishes for all its readers a very happy holiday season. To our contributors and many helpers we extend our very best wishes and thanks for the kindnesses of the past year and our sincere hope that 1965 will bring all that you can desire.

The Editor

ABSTRACT OF MINUTES OF COUNCIL SOUTH CAROLINA MEDICAL ASSOCIATION OCTOBER 14, 1964

Dr. Eaddy read the report from the Committee on Mental Health, and pointed out that Council was directed by the House of Delegates to consider ways and means to support, and assist in the work of the S. C. Mental Health Commission. Motion was made by Dr. Cain that Council go on record as approving legislation providing for a medical doctor to be in charge of the overall mental health facilities, state and local, and instruct the Legislative Committee to try to get appropriate legislation passed. Seconded. Passed.

Dr. Owens moved that the request to try to get clarification on physicians charge for office physiotherapy; i.e, whether or not the Industrial Commission will pay for an office visit and physiotherapy if there is no licensed Physiotherapist, be referred to Dr. Siegling's Committee on Industrial Fee Schedule. Seconded. Passed.

Dr. Owens read a letter from Dr. Heyward H. Fouche, Chief of Staff, Columbia Hospital, recommending that certain changes be considered in the present South Carolina laws relative to autopsies. Dr. Owens moved that this matter be referred to Mr. Meadors requesting that he investigate the legality of such changes and he, in turn, confer with the Legislative Committee for their consideration and recommendations to Council. Seconded. Passed.

The Accident Prevention Committee's previous recommendation regarding tetanus immunization was discussed. Dr. Perry presiding.. Dr. Peeples of the State Department of Health came in and discussed this program and outlined the available federal aid. Dr. Owens moved that Council go on record as urging tetanus toxoid immunization for the people of this state and that a committee be appointed by the President to consider and investigate methods of implementing this program and report to the next meeting of Council. Seconded. Passed.

Colonel Davis was asked to present recommendations regarding Medicare for service dependents. Dr. Eaddy asked Dr. Owens, Dr. Cain, and Mr. Meadors to consider renegotiating a formal contract with Medicare and bring some recommendations to the House of Delegates.

Dr. Kilgore gave a report of the Committee on Legislation and Public Relations. Several recommendations of the committee were discussed. Dr. Owens moved to direct the Legislative Committee to press for passage of the proposed legislation regarding the "Battered Child." Seconded. Passed.

With regard to the Legislative Committee's recommendation on blood donor insurance, Dr. Booker moved that Council go on record as opposing insurance company payment for blood (actual blood) and that the Insurance Commission be notified that Council opposes blood donor insurance, and give reasons. Seconded. Passed.

Mr. Meadors discussed the newspaper ads prepared and financed by the AMA, as a part of its "National Educational Program on Health Care for the Aged." These ads are ready to go out to the various newspapers over the state for publication over the name of SCMA, with the County Medical Societies also participating if they so choose. Dr. Cain moved that Council recommend following AMA publicity as outlined by Mr. Meadors and when this has been completed, if the recommendations by Dr. Hayne's committee have not been fulfilled, SCMA will take this on as a separate attitude. Seconded. Passed.

Dr. James Hayne gave the report of the "Ad Hoc" Committee on MAA (Kerr-Mills) in South Carolina. The following recommendations were adopted.

1. That income and cash assets above the limitations now set be applied to medical expenses and MAA be available when these are exhausted.

2. That the income limitations be raised from $1400 to $1500 for a single person. For a man and wife the combined income be raised to $2500.

3. That savings limitations be raised from $500 to $1000 for a single person, and for a man and wife from $800 to $1500.

4. Other stipulations as to exclusions to remain in statu quo.

5. That application for this program shall be made to the County Health Dept. instead of the Welfare Dept.

6. That the County Health Dept. shall refer these applications to the Welfare Dept. for investigation and processing.

Council went on record as opposing a recommendation that provision for payment of physicians' services in the hospital be provided for.

Dr. William A. Klauber, President, Alumni Association of the Medical College was called on for a report from the Alumni Association as to relationship to the Annual Meeting of SCMA.

Dr. Evatt moved that the details of SCMA Annual Meeting be left to the Program Committee. Seconded. Passed.

Dr. Cain reported on two insurance contracts (major medical) which the Insurance Committee desires Council to authorize approval of these two plans until next May meeting of SCMA so that these plans can be sold to physicians on an independent basis until approved by the House of Delegates. Dr. Black moved that Council instruct the Insurance Committee to take any action they feel is necessary to contract with the companies for these two plans. Seconded. Passed.

The SCMA Permanent Home was discussed. Dr. Owens moved that the committee that considered this last year be reactivated and instructed to investigate possible sites in and around Columbia, and make recommendations at the next meeting of Council regarding the purchase of such property, also if any vacancies exist on this committee, the new members are to be appointed by the Chairman of Council. Seconded. Passed by majority vote 8 to 3.

Dr. Owens moved that a meeting be arranged with Mr. Meadors, the County Medical Society Officers and the Committee on Public Relations for the purpose of considering ways of reinforcing efforts of AMA referable to health care for the aged. Seconded. Passed.

Dr. Green was not available to give the report of the Committee on Doctor Procurement. Dr. Owens moved that the Committee on Doctor Procurement implement the resolution aimed at alleviating shortage of physicians, and that the committee meet with the President of the Academy of General Practice and a member of the faculty of the Medical College. Seconded. Passed.

Dr. Evatt gave a report of the Special Committee on Finance. Dr. Evatt moved that the Treasurer and Executive Secretary be authorized to sell $10,000.00 of shares in Mutual Investment Fund to apply to existing indebtedness of the Association. Seconded. Passed.

Dr. Evatt moved that the shares in the Investors Stock Fund (invested from receipts for Permanent Home) be disposed of and the proceeds deposited in several Building and Loan Associations over the State in the name of the Permanent Home Building Fund so as to have a more equitable distribution of reserve funds and probably produce greater income, and that such income be retained in the Building Fund. Seconded. Passed.

Dr. Evatt moved that the Executive Secretary be authorized and instructed to take a thousand dollar increase in salary. Seconded. Passed.

The Budget for 1964 and disbursements to September 30, 1964 were reviewed in detail and the Budget as proposed for 1965 was adopted. (Only the changes are shown in this draft of the minutes).

Secretary		
Office Help	$ 900.00	
Office Expense	300.00	
Secretary's Travel	300.00	
		$ 1,500.00
Journal		
Editor's Salary	2,400.00	
Editor's Office Expense	1,500.00	
Adv. Mgr.'s Salary	1,200.00	
Printing	25,000.00	
		$30,100.00
Executive Office		
Exec. Sec'y.'s Salary	13,000.00	
Office Help	9,500.00	
Travel	1,800.00	
Rent	1,700.00	
Office Supplies	1,350.00	
		$27,350.00
Woman's Auxiliary		
Appropriation from Assn.	2,000.00	
Auxiliary Bulletin	1,000.00	
		$ 3,000.00
General Expense		
Delegate to Student AMA	200.00	
Newsletter	750.00	
Student Loan Fund	Eliminated	
(Other items under general expense remain the same)		
Total General Expense		
(Includes items not listed)		$15,150.00
TOTALS		
(Revised Budget 1965)		$85,500.00
TOTAL (Budget 1964)		$85,650.00

(Dr. Perry presiding). Dr. Eaddy recommended that Council look into the possibilities of the State Board of Medical Examiners including in their Directory the doctors' phone numbers, and indicate if they are members of SCMA, so that SCMA could dispense with their Directory. It was pointed out that it is too late for anything to be done about the current Directory. Dr. Owens moved that Dr. Stokes, Treasurer, confer with the State Board of Medical Examiners referable to the described Directory. Seconded. Passed.

Dr. Eaddy gave the report of the Committee on Industrial Fee Schedule as Dr. Siegling was unable to attend this meeting. Dr. Owens moved that a copy of the fee schedule be furnished each member of Council. Seconded. Passed.

Dr. Owens moved that the procedure for taking and recording the minutes of the SCMA annual meetings be left to Dr. Price and Mr. Meadors. Seconded. Passed.

Dr. Owens moved that Chairman of Council appoint a committee to Review Economic and Professional Practices and Policies of Hospital and State Institutions and Agencies whose work deals with the Practice of Medicine. Seconded. Passed. The Secretary was instructed to notify the members of this committee, namely, Dr. Richard W. Hanckel, Jr., Charleston, Dr. James W. Fouche, Columbia, Dr. William H. Hunter, Clemson, and Dr. James B. Gowan, Greenville. (One other member to be appointed.)

Ben N. Miller, M. D., Secretary

LIAISON WITH THE INSURANCE BUSINESS

William T. Hendrix, M. D.

One of the startling phenomena of our times has been the rapid growth of the various forms of voluntary health insurance in the past few years. This growth has been accompanied by an increasing dependence of insurance on the cooperation of physicians and an increasing impact of insurance on the income of physicians. Effective liaison between the medical profession and the business of insurance is therefore of ever greater importance. Initiation of such liaison in our state by the Health Insurance Liaison Committee of the South Carolina Medical Association and the Health Insurance Council of South Carolina has been announced in a letter sent to all physicians in the state. The purpose of this article is to further describe the two liaison groups and their projects, and to review the extent of voluntary health insurance coverage and its effect on physicians.

Growth and Extent of Voluntary Health Insurance

Health insurance has two functions: replacement of income lost because of accident or illness, and reimbursement of expenses incurred because of accident or illness. It is insurance against the expense of accident or illness—usually subdivided by type of expense (hospital, surgical, regular medical and major medical)—that has experienced the startling growth referred to above. Hospital expense protection, paying for part or all of the daily service and miscellaneous service charges of hospitals, has increased by two-thirds in the United States, and tripled in South Carolina since the end of 1951. Surgical expense protection, paying part or all of surgeons' charges, has doubled in the United States and more than tripled in South Carolina. Regular medical expense protection, paying part or all of doctors' non-surgical charges for hospital, home, or office visits, has increased three and one-half times in the United States and more than six times in South Carolina. And coverage under major medical expense insurance, providing protection against the major cost of virtually all types of health care, has grown to its present significant size from practically nothing in 1951.

The growth in voluntary health insurance has been shared by insurance companies, Blue Cross and Blue Shield plans, and independent plans, although the fastest growth has been in the numbers covered by insurance companies.

Dependence of Insurance on Cooperation of Physicians

The effectiveness of health insurance depends to a considerable extent on the cooperation of the insured patient's physician. It is the physician who decides what treatment the patient should receive, whether he should go to the hospital and how long he should stay, when he may return to work. The physician's decisions in these matters play a large role in determining the expense to the patient and hence the amount of the benefit payable. Furthermore, the physician's certification as to the type and amount of expense, or the time lost from work, is an essential part of the proof of loss which the patient must furnish in order to collect his benefits.

The physician is, in fact, triply important in the functioning of health insurance. Policy benefits are designed and priced with due regard for what medical practice has been in the past. The usefulness of those benefits to the insured population, and the ability of the insurance companies to pay them out of the premiums received for them, depend on a reasonable continuity in practices and fees. Finally, the payment of benefits in a particular case, in a manner and amount that is fair both to the claimant and to all other policyholders, depends largely on the physician's certification.

Impact of Insurance on Income and Expenses of Physicians

Health insurance has an obvious effect on the physician's income. It is easier to collect his fees from a patient who will be reimbursed in full or in part than from a patient who has no such prospect. Some people who would otherwise be service patients are able to pay. Arrangements can be made for payment direct to the doctor. It must be remembered, however, that health insurance does not create new money. It simply means that everyone pays the average cost of medical care, instead of most people paying much less than the average and a few people paying—or failing to pay—much more.

Health insurance also increases the doctor's expenses, because of the time required to complete his patients' claim forms. Filling out forms is necessary, however, if the patients are to get the benefits they have paid for, and it may also be necessary if the doctor is to be paid. The number of forms is likely to increase, as the number of policyholders increases. Nevertheless, completing them is not the problem that it used to be, when every company in the business had a different idea of what information was needed and how it should be requested. Most companies today use the standard claim forms approved by the Health Insurance Council and the American Medical Association, so that even with optional variations allowed, there is considerable similarity among the forms of different companies. Thus the doctor has only one set of questions to interpret, rather than several hundred, in deciding what information is wanted.

DISTRIBUTION OF HOSPITAL, SURGICAL, AND REGULAR MEDICAL EXPENSE COVERAGE IN THE UNITED STATES BY TYPE OF INSURING ORGANIZATION DECEMBER 31, 1963

Number of People Protected

(000 omitted)

Type of Insuring Organizations	Hospital Expense	Surgical Expense	Regular Medical Expense
Insurance Companies:			
Group Insurance	60,547	60,944	42,066
Individual-Policy Ins.	38,065	33,745	11,884
Unadjusted Total	98,612	94,689	53,950
Deduction for Duplication in Persons with Insurance Company Protection	10,485	9,731	4,242
Net Total for Insurance Companies	88,127	84,958	49,708
Blue Cross, Blue Shield and Medical Society Plans:	61,659	52,474	49,302
Independent Plans:			
Industrial Plans	4,814	4,806	4,398
Community Plans	1,947	3,206	3,093
Private Group Clinics	60	250	256
College Health Plans	400	300	900
Total for Independent Plans	7,221	8,562	8,647
Deduction for Duplication:			
Persons Protected by More Than One Type of Insuring Organization	11,678	11,086	5,480
Net Total Persons Protected	145,329	134,908	102,177

Source: Health Insurance Council, *The Extent of Voluntary Health Insurance Coverage in the United States as of December 31, 1963.*

The Health Insurance Council

The Health Insurance Council is a federation of eight insurance associations whose members account for over 90 percent of the health insurance issued by insurance companies. It was formed nearly twenty years ago to serve as a central source of information and technical assistance on health insurance to physicians, hospitals and other providers of health services. Among its projects are the uniform forms program mentioned above; a corresponding program with respect to hospital insurance claim forms (including procedures to facilitate hospital admissions and credit for insured patients); the compilation and publication of an annual survey of the extent of voluntary health insurance; publication of various booklets, pamphlets, and bulletins on health insurance; and liaison with national organizations of physicians and hospitals, in order to exchange facts and viewpoints on common problems.

Committees of the Health Insurance Council have been formed in every state to contact and work with local medical, hospital, and allied health organizations. Composed of local insurance representatives, these committees carry forward the purpose and programs of the Council, seeking to resolve at the community level problems of mutual interest to health insurance and the providers of medical services. The Council's committee in this state is known as the Health Insurance Council of South Carolina. Its Chairman is Mr. George H. Hipp, Vice President of Liberty Life Insurance Company, Greenville, while Dr. Willard B. Mills, Medical Director of the same company, is Chairman of the Medical Relations Subcommittee.

The Health Insurance Liaison Committee of the South Carolina Medical Association

The South Carolina Medical Association has recently established a Health Insurance Liaison Committee of which the author serves as Chairman, as a formal channel for liaison with the health insurance business. The Committee invites communications from any doctor in the state with questions or suggestions concerning voluntary health insurance of its practices.

Proposed Joint Projects

At the first joint meeting of the Health Insurance Liaison Committee of the South Carolina Medical Association and the Health Insurance Council of South Carolina, held on November 21, 1963, a number of joint projects were proposed. These included the joint letter to every physician in the state, which was sent early this year, and showing of a Health Insurance Council Exhibit at the 1964 Annual Meeting of the South Carolina Medical Association, which has also been done. In addition, it was agreed that articles would be prepared for the *Journal of The South Carolina Medical Association*, to explain more

fully health insurance and the coverage it provides; pamphlets on health insurance would be prepared, for physicians to make available to their patients; Health Insurance Council material concerning claim forms would be distributed; and speakers on health insurance matters would be provided on request. Arrangements were made for further joint meetings, which continue to be held every few months.

It is hoped that progress on all these projects will become apparent in the next few months and that the liaison which has begun so well will result in improved service to patients and policyholders.

DISTRIBUTION OF HOSPITAL, SURGICAL, AND REGULAR MEDICAL EXPENSE COVERAGE IN SOUTH CAROLINA BY TYPE OF INSURING ORGANIZATION DECEMBER 31, 1963

Number of People Protected

(000 omitted)

Type of Insuring Organizations	Hospital Expense	Surgical Expense	Regular Medical Expense
Insurance Companies:			
Group Insurance	970	953	301
Individual Policy Insurance	945	582	150
Unadjusted Total	1,915	1,535	451
Deduction for Duplication in Persons with Insurance Company Protection	318	189	25
Net Total for Insurance	1,597	1,346	426
Blue Cross, Blue Shield and Medical Society Plans	267	250	237
Independent Plans	21	17	19
Deduction for Duplication: Persons Protected by More Than One Type of Insuring Organization	99	99	17
Net Total Persons Protected	1,786	1,514	665

Source: Health Insurance Council, unpublished data from 18th Annual Survey.

EXTENT OF MAJOR MEDICAL EXPENSE, DECEMBER 31, 1963

(000 omitted)

Type of Protection	United States	South Carolina
Group Insurance:		
Supplementary	28,248	298
Comprehensive	10,020	76
Total	38,268	374
Individual-Policy Insurance:	3,742	22
Grand Total	42,010	396

Source: Health Insurance Council, *The Extent of Voluntary Health Insurance Coverage in the United States as of December 31, 1963*, August 1964, and unpublished data from 18th Annual Survey.

Members of the South Carolina Medical Association reading papers before other organizations are requested to submit their papers to the JOURNAL for consideration by the Editorial Board for publication. Please send papers to:

Joseph I. Waring, M. D., Editor
Journal of the South Carolina Medical Association
82 Rutledge Avenue
Charleston, South Carolina

News

Dr. Miller Joins Group In Practice

Joe H. Miller, III, M. D. has joined the group of Drs. Barron, Fairey and Slocum in the practice of urological surgery in Columbia.

Dr. Miller graduated from Davidson College and then obtained his medical education at Emory University. He took his internship and first year of surgical residency at Grady Memorial Hospital. From there he entered the U. S. Navy, attended the School of Aviation Medicine in Pensacola, Fla., and served as flight surgeon at the Naval Air Test Center at Patuxent River, Maryland.

Before coming to Columbia he trained in urological surgery at the Boston City Hospital.

Dr. J. H. Cathcart, Jr. To Practice In Gaffney

Dr. John H. Cathcart, Jr., son of Dr. and Mrs. John H. Cathcart has announced the opening of a practice limited to obstetrics and gynecology with an office located with Doctors Cathcart, Hall and Edwards.

Dr. Cathcart, a graduate of Davidson College and the Medical College of South Carolina (1960) has just completed one year internship and three years residency at the hospital of the University of Pennsylvania, Philadelphia.

Dr. Roderick Macdonald

Dr. Roderick Macdonald of Rock Hill has been elected to the Board of the National Medical Foundation for Eye Care.

Dr. George Dean Johnson

Dr. George Dean Johnson of Spartanburg is on the Reference Committee of the House of Delegates on Reports of Officers at the November meeting of the American Medical Association.

Dr. Siddon Joins Springs Medical Dept.

Dr. William H. Siddon has joined the Medical Department of The Springs Cotton Mills.

Dr. Siddon will be based in Chester and will serve the Gayle, Springsteen and Eureka Plants.

A native of Sweatman, Mississippi, Dr. Siddon received his medical degree from the University of Tennessee in 1941. He interned in St. Joseph Hospital, Memphis, Tennessee.

In July of 1942, Dr. Siddon was commissioned a first lieutenant in the U. S. Army. He was enrolled in the University of Tennessee Medical School for special post graduate study of clinical pathology.

Dr. Siddon was discharged from the Army in 1946 with the rank of Major and from July 1946 to January 1948 he was an instructor in internal medicine in the University of Arkansas Medical School in Little Rock, Arkansas. From 1948 until the present he has been in the practice of internal medicine in Orange, Texas.

His private practice in Orange was confined to internal medicine, with emphasis in cardiology. He was an electrocardiographer at the Lutcher Hospital of Orange, Texas.

Dr. Siddon is a member of the Orange County medical society, the Texas medical association, the American Medical Association, and the Phi Chi Medical fraternity.

Nursing Home Planned At Georgetown

A $750,000 nursing home that will be one of the largest buildings in Georgetown will be erected in Maryville.

The structure will provide 80 beds for elderly citizens.

Construction is expected to begin in December on a site in the 2700 block on South Island Road. Work on the proposed building is expected to be completed within about six months.

It will provide private and semi-private rooms with air-conditioning and central heating.

Dr. Otis Hill At Enoree

Dr. Otis Hill, native of Sumter, has begun his practice of medicine at Enoree.

A 1963 graduate of Medical College of South Carolina, Dr. Hill recently completed his internship at Spartanburg General Hospital.

Dr. Furman Wallace

Presbyterian College presented its 1964 Alumni Gold P Award to Dr. Furman T. Wallace, Spartanburg surgeon, at the special Homecoming program Saturday afternoon, October 10.

Dr. Wallace was chosen to receive this high stamp of approval by the alumni board of directors for "outstanding accomplishments in his chosen profession which reflect credit upon Presbyterian College."

Dr. Neeley Joins Dr. Holman

Dr. Ben Neeley of Augusta, Georgia, has arrived in Timmonsville to become associated with Dr. David O. Holman as a general practitioner.

Dr. Neeley is a graduate of the Georgia Medical College and served his residency at the Columbia Hospital.

Dr. Wade Temple Heads District Heart Fund

Dr. L. Wade Temple, of Lake View will be chairman of the Eastern Division of the state's 1965 Heart Fund campaign.

Dr. Baroody Elected

A Florence physician, Dr. Albert Baroody, is the newly installed president of the Obstetrical and Gynecology Society of South Carolina. He was installed at the annual meeting of the society held in Spartanburg.

Dr. Baroody succeeds Dr. Wardlaw Hammond of Spartanburg.

Dr. Julian Salley of Columbia continues as secretary-treasurer.

The society has approximately 90 members.

National Community Health Week

The S. C. Medical Association and the S. C. State Board of Health joined in paying tribute to individual and community efforts for better health in South Carolina.

In a joint release observing National Community Health Week, October 18-24, Dr. Frank C. Owens, president of the S. C. Medical Association, and Dr. G. S. T. Peeples, state health officer, called attention to the development of health facilities and services throughout the state which have been made possible through cooperative civic and professional action.

Noting achievements of the past several decades by medicine and public health, their statement emphasized the reduction of death rates from such diseases as malaria, yellow fever, typhoid fever, tuberculosis, pellagra, pneumonia and influenza and others, and points to the development of modern hospitals, expansion of public health facilities and services, growth of voluntary health insurance programs and public awareness of good health practices as contributing factors.

The joint statement called attention to the responsibility of every citizen for providing adequate health resources in each community and encourages every South Carolinian to become familiar with the resources that are available and also those that will be needed to meet community health needs in the future.

The national observance of Community Health Week, started last year by the American Medical Association, is supported by local and state medical and dental associations and all county health departments.

Deaths

Dr. W. W. Wild

Dr. Willard W. Wild died November 1 at his residence in North Charleston. He was 73.

Dr. Wild was born September 19, 1891 in Carbon, Iowa.

A graduate of St. Louis University, Dr. Wild served as a medical officer in the Navy during World War I and moved to Charleston in 1918. He served as company physician for General Asbestos and Rubber Co. of North Charleston for 40 years.

He retired from his practice as a physician about two years ago.

Dr. Wild was a member of Park Circle Presbyterian Church. He was a member of Hammerton Lodge No. 332 AFM, the American Medical Assn. and state and county medical associations, and was a member of the board of directors of the South Carolina National Bank.

Dr. J. C. Moore

Dr. James Carlisle Moore, Jr., of Myrtle Beach, died October 24.

Dr. Moore was born in McColl on Aug. 30, 1903, a son of the late Dr. James Carlisle Moore and Myrtle Tatum Moore. He was a retired physician.

Dr. Moore attended Wofford College and was graduated from the Medical College of South Carolina in 1928. He interned in Charleston and in New York.

He practiced medicine in McColl until his retirement because of ill health in 1961. He was a member of the South Carolina and Marlboro County Medical Associations, and the Seaboard Air Line Surgeons Association.

Dr. C. T. Holloway

Dr. Charles Thomas Holloway, a practicing Negro physician for the past 29 years in Charleston, died November 7.

A native of Marion, where he was born January 23, 1909, he completed undergraduate work at Lincoln University in Pennsylvania in 1930. He completed work at Meharry Medical College in 1935. He was valedictorian of his graduating classes in high school, college and medical school.

After internship in Kansas City General Hospital, he had a year's residency at Provident Hospital, Chicago, before returning to Charleston and opening his practice.

He was a member of the Palmetto Medical, Dental and Pharmaceutical Association, the Charleston County Medical Society, the S. C. Medical Association, and the American Medical Association.

Book Reviews



GIVE AND TAKE, THE DEVELOPMENT OF TISSUE TRANSPLANTATION. Francis D. Moore, M. D. Pages: 182. Illustrated. 1964. $5.50. W. B. Saunders Company, Philadelphia, London.

It is probable that Dr. Francis Moore, Moseley Professor of Surgery and Surgeon-in-Chief at the Peter Bent Brigham Hospital in Boston, is one of the most versatile men in medicine. Beyond his other talents, his is a rather unique gift of providing the pleasure of acquiring knowledge. In his latest book, "Give and Take, the Development of Tissue Transplantation," Moore has written a lucid, concise, and enjoyable compendium on the subject of tissue transplantation. The very attempt of writing such a book is an ambitious project. The magnitude of such an endeavor is inherent in the complexity of transplanting a whole functional organ system from one strange human being to another. Moore has explained this complexity well and briefly. The brevity of this book (182 pages) provides its readability in an evening. The organization is such as to subtly lead the layman or physician through a veritable briarpatch of history, surgery, chemistry, legality, and philosophy, without scratch or anguish.

The book is divided into eleven brief chapters. These chapters in turn first begin by imparting information relative to the mechanisms by which the human body is peculiarly unique, intrinsically resisting the effort to place within it a tissue from another living organism. Further chapters delineate the imagination, effort, and ingenuity by which the body's natural immune response has been suppressed by the scientist in order to allow successful grafting from one organism to another. These chapters take the reader through the history of man's effort to trade within the living organism a healthy piece of functional tissue for a diseased portion. These problems, efforts and developments are put to the reader in rather simple terms with an amplitude of original quotations, illustrations and interesting case presentations. The last chapters contain the author's own comments as to the prevalent and futuristic means of dealing with specific organ problems. There is also contained the ever-present legal complications, and the mode of how these legalities must need be dealt with by both the physician and patient. While this is indeed a scientific undertaking, it is well polished by ending with a consideration of the philosophical union of the quick, the dead, and the physician.

In summary, "Give and Take" is an intriguing scientific story written by a master physician-surgeon-scientist. It efficiently and painlessly transplants knowledge of the present status of the graft.

Gilbert B. Bradham

CARDIAC ARREST AND RESUSCITATION. 2nd Edition. Edited by Hugh E. Stephenson, Jr. The C. V. Mosby Company. 1964.

This is a good book which contains discussions of the mechanisms, diagnosis, management, pitfalls, prevention and prognosis of cardiac arrest as viewed in 1964. Many prominent physicians are contributors. The text is augmented mostly by excellent and typical illustrations. The material is presented systematically and in this respect is most informative and useful, particularly to the medical student and general practioner. In addition, because it is very complete, it will serve as an excellent reference for doctors in teaching or research.

P. C. Gazes, M. D.

TEXTBOOK OF PEDIATRICS, by Waldo E. Nelson, M. D. Eighth Edition. W. B. Saunders Company, Philadelphia and London. 1964. Pp. 1636. $18.00.

The eighth edition of this well-known and highly regarded text now offers some 1600 pages of material furnished by numerous authoritative contributors and welded into a pleasingly cohesive product by the editor. Many articles have been brought up to date and much new matter has been added, especially in the field of diseases of antenatal origin.

Undoubtedly, this is the practitioner's pediatric Bible of the day.

JIW

MEDICAL PHARMACOLOGY PRINCIPLES AND CONCEPTS, by Andres Goth, M. D. 2nd Edition. The C. V. Mosby Company, Saint Louis. 1964. Pp. 585. $11.75.

This is a brief and clearly written presentation with emphasis on mechanistic concepts rather than on therapeutic detail. The material corresponds approximately to what might be expected to be presented to medical students in a regular course in pharmacology. Since Dr. Goth is an experienced teacher, he has competently selected the drugs of chief current interest and explained their action in a manner which is readily grasped. The material is well illustrated by structural chemical formulas, selected diagrams from the literature, and by diagrams expressly prepared

for this volume. References at the end of each chapter include both basic, classic background studies as well as current reports. The volume is well recommended for someone who wishes an up-to-date, readable review of the subject.

R. P. Walton, M. D.

A MARRIAGE MANUAL FOR CATHOLICS, by William A. Lynch, M. D. Trident Press, New York. 1964. $4.95.

Dr. Lynch has made a desirable contribution to all professionals concerned with advising and counselling the parade of happy couples anticipating marriage, and also those learning the difficult art of complementing each other within the marriage bond. His approach is a fresh one, compounded of knowledge not only of the physical and emotional requisites for perfection of this great state, but well filled with a highly personalized yet completely documented insight into the practical applications of morals and ethics as such pertain to the married couple. Particularly appealing is his candid and hopeful approach to the problems of responsible parenthood. There is complete acknowledgment of the problems of family limitation, and every facet of the mind of the church on this important problem is explored and thoroughly and lucidly explained. Since this is such a complete manual, treating of every basic subject from dating to marriage, thence to the twilight time of enduring love of the Golden Anniversary couple, each with its special duty as well as its special privilege in the Divine plan, it would be an excellent text for the physician, the clergyman, and all those needing an easy authoritative method of knowing what the Catholic Church teaches in the many situations that arise. I recommend this volume highly.

Patricia A. Carter, M. D.

EMERGENCY TREATMENT AND MANAGEMENT, by Thomas Flint, Jr. Third Edition. Pp. 686. $8.75. W. B. Saunders Company, Philadelphia. 1964.

While concise, this comprehensive handbook offers a full gamut of emergency treatment and management policies in a clear fashion. Obviously well thought out and planned, this emergency manual includes conditions generally expected in such a compendium and, in addition, covers subjects not easily found in a single volume, such as problems of addiction, management of death cases, drug dosage, suggested contents for medical bag, fluid replacement principles, use of narcotics in emergency care, medico-legal considerations, methods of resuscitation, immune disorders, suicide, and various emergency and surgical procedure techniques. Emergency treatments have been outlined in easy-to-find order for the various body systems and in addition for the usual categories of emergency problems.

This book should serve as a reliable and helpful manual for nurses, medical students, hospital housestaff, and practitioners dealing with medical emergencies outside of an institutional emergency room establishment.

Harry Gregorie, M. D.

MASSAGE, PRINCIPLES AND TECHNIQUES. Gertrude Beard, R.N., R.P.T., and E. C. Wood, R.P.T. W. B. Saunders Company, Philadelphia and London, 1964. Pp. 163. $6.

Both authors are well known and highly respected in the field of physical medicine and rehabilitation. The book is clearly written and illustrated, and shows that massage is not just "rubbing" or "laying on the hands," but an art—employed by well trained technicians,—and can be of great value in hastening patients' recovery.

This book presents a fine picture of the history, principles and effects of massage and should be read and reread by everybody in the field of physical education and medicine. Medical students, particularly, can gain wider knowledge and understanding of basic physical therapeutic methods for their future care of patients.

The benefits and knowledge received by studying this book will be rewarding by seeing patients recover more fully.

M.S.F.

OUTLINE OF UROLOGY by Charles Creevy. 1st Edition. McGraw-Hill Book Co., New York. 1964. Pp. 385. $7.95.

Originally serving as a guide for medical students, this work was expanded into a reference work in urology for use by residents and general practitioners as well. It is organized along the lines of disease process rather than systems involved; adequately illustrated, well referenced, and written in easy to read and easy to understand terms. In some areas the material has not been brought up to date. An example is found on page 40: "A more recent development is the Foley catheter, ...".

On the whole, the author has accomplished his stated purpose. As an outline the entire field of urology is covered but in no great detail or depth. The abundant and excellent references, however, easily lead the reader to sources which go into more detail on any specific subject of interest. The references alone would make this a desirable book for urologists.

Raymond Rosenblum, M. D.

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The Doctor's Visit, Jan Steen 1626-1679, Mauritshuis, The Hague

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1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

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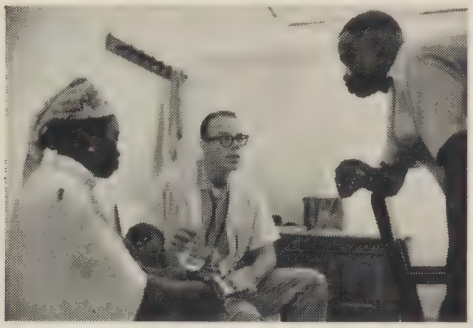
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"My colleagues thought I was crazy!"

Nick Cunningham, M.D., was eminently qualified for any number of promising medical posts here at home. Harvard pre-med. Hopkins medical. London's Guys Hospital. New York's Presbyterian Hospital.

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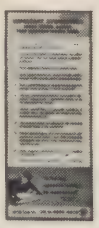
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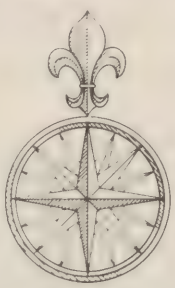




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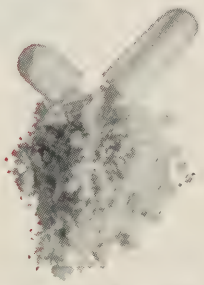
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1. Sweeney, W. M.; Dornbush, A. C., and Hardy, S. M.: Demethylchlortetracycline and Tetracycline Compared. Relative *in vitro* Activity and Comparative Serum Concentrations During 7 Days of Continuous Therapy. *Amer. J. Med. Sci.* 243:296 (Mar.) 1962.

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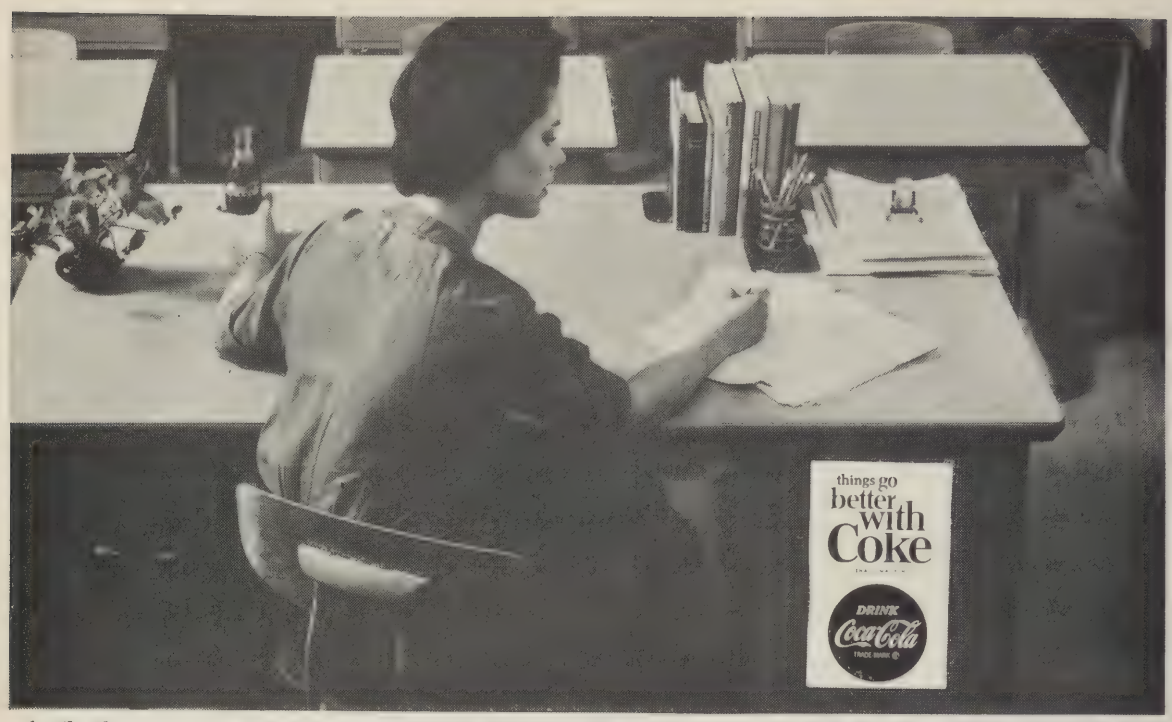
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*Clinical report on file, Medical Department, A. H. Robins Co., Inc.

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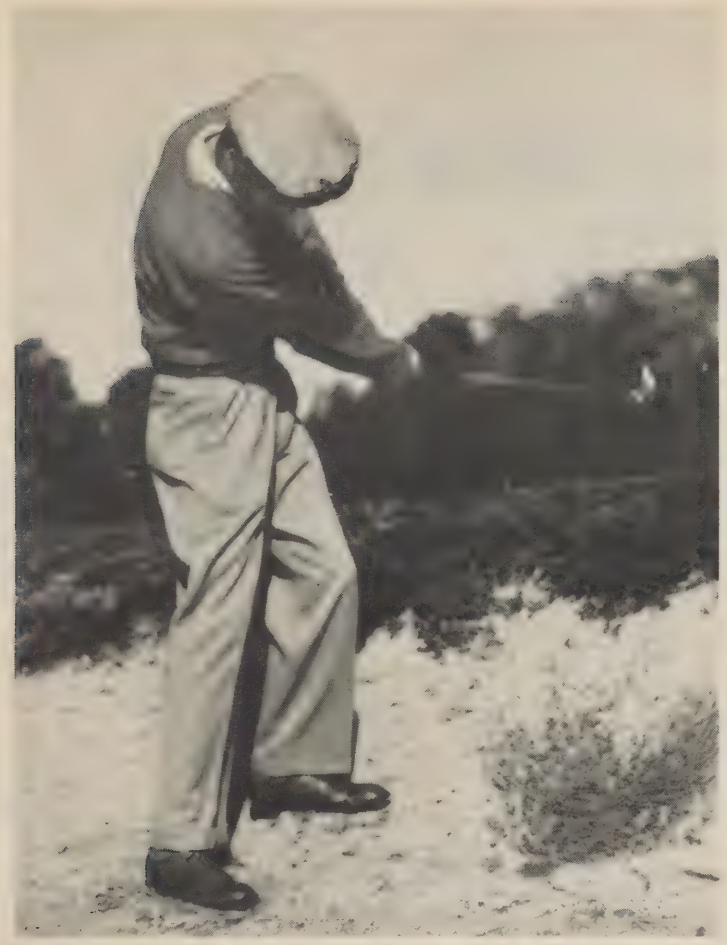
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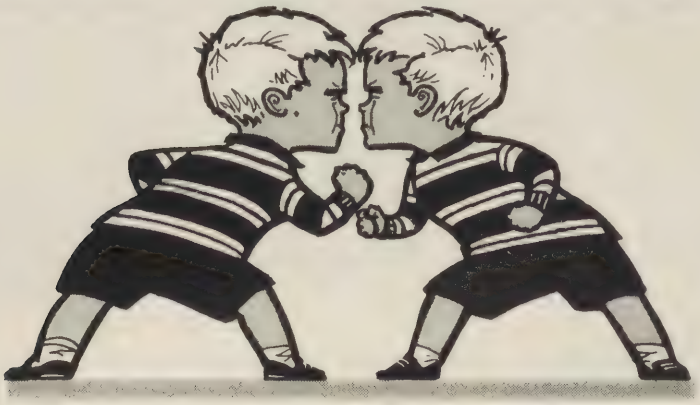
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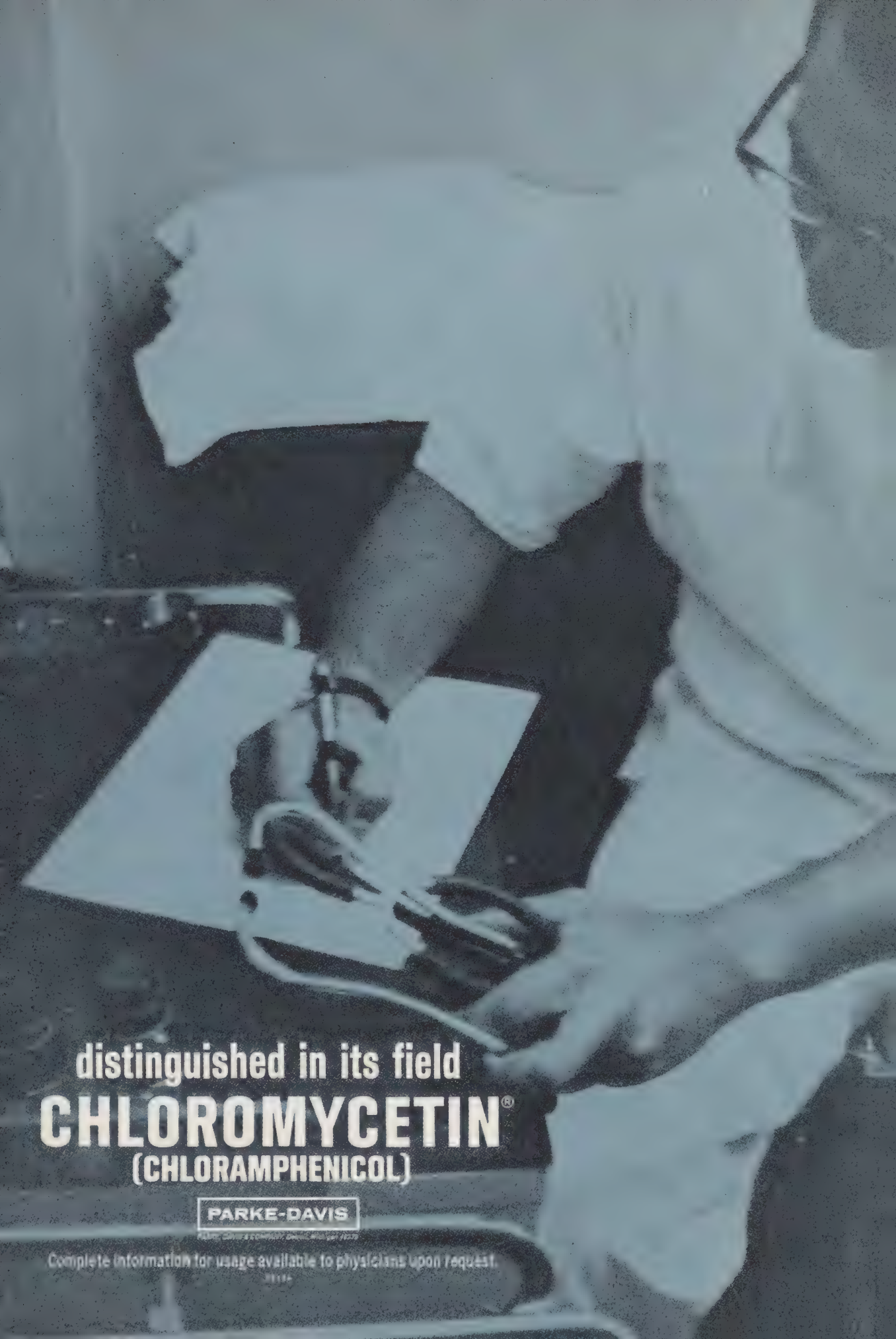
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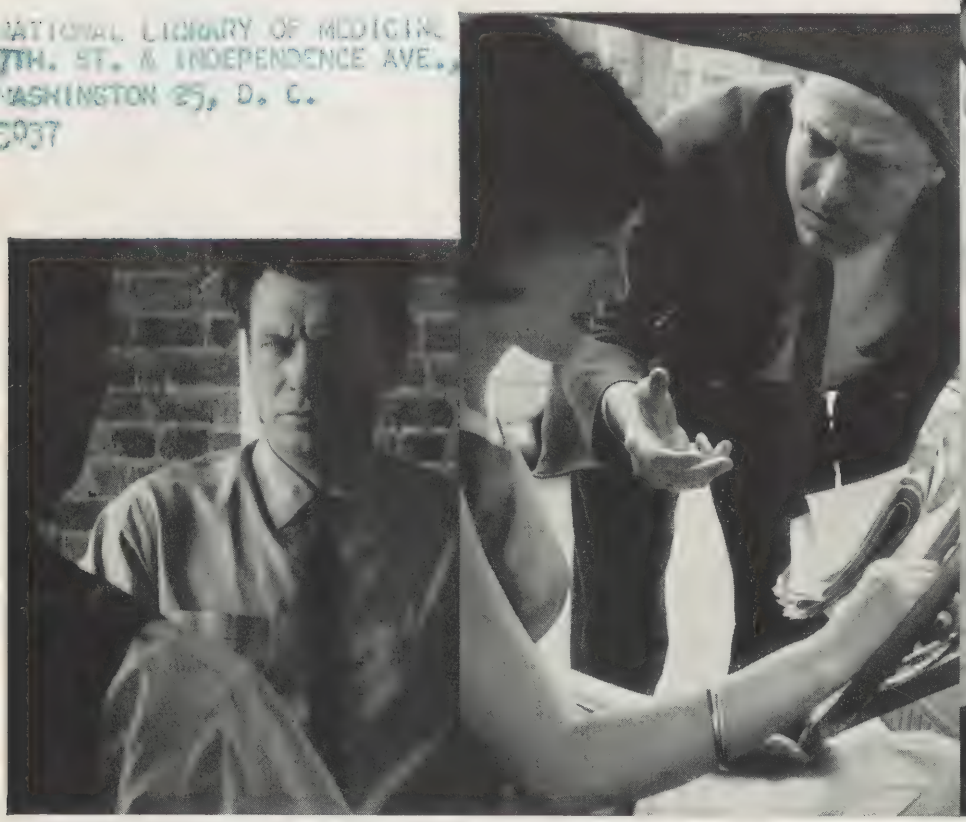
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How to prescribe Valium (diazepam)

Indications: Valium (diazepam) is of use in dealing with anxiety reactions stemming from stressful circumstances or whenever somatic complaints are concomitants of emotional factors. It is useful in psychoneurotic states manifested by anxiety, tension, fear and fatigue.

Valium (diazepam) may also be useful in acute agitation due to alcohol withdrawal.

Valium (diazepam) may be of use to alleviate muscle spasm associated with cerebral palsy and athetosis.

Dosage and administration	*Usual daily dose*
Mild to moderate psychoneurotic reactions: Manifested by anxiety-tension alone or with depressive symptomatology, agitation, restlessness, psychophysiological disturbances	2 mg to 5 mg, 2 or 3 times daily
Severe psychoneurotic reactions: Where severe anxiety, fear, agitation, aggression or hostility exist alone or with depressive symptoms	5 mg to 10 mg, 3 or 4 times daily
Alcoholism: As an aid in symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis	10 mg, 3 or 4 times during the first 24 hours; reducing to 5 mg, 3 or 4 times daily as needed
Muscle spasm associated with cerebral palsy or athetosis	2 mg to 10 mg, 3 or 4 times daily

Contraindications: Valium (diazepam) is contraindicated in infants, patients with a history of convulsive disorders or patients with a history of glaucoma.

Warning: Valium (diazepam) is not of value in the treatment of psychotic patients, and for this reason should not be employed in lieu of appropriate treatment.

Precautions: In elderly or debilitated patients, it is important to limit the dosage to the smallest effective amount to preclude the development of ataxia or oversedation (not more than 1 mg, 1 or 2 times daily initially, to be increased gradually as needed and tolerated). As is true of all CNS-acting drugs, until the correct maintenance dosage is established, patients receiving Valium (diazepam) should be advised against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving an automobile during the period of Valium (diazepam) therapy is not recommended. In general, the concurrent administration of Valium (diazepam) and other psychotropic agents is not recommended. If such combination therapy is used, careful consideration should be given to the pharmacology of the agents to be employed with Valium (diazepam)—particularly with known compounds which may potentiate the action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants.

Since Valium (diazepam) has a central nervous system depressant effect, patients should be advised against the simultaneous ingestion of alcohol and other central nervous system depressant drugs during Valium (diazepam) therapy. Safe use of Valium (diazepam) during pregnancy has not been established. The usual precautions are indicated when Valium (diazepam) is used in the treatment of anxiety states where there is any evidence of impending depression; particularly the recognition that suicidal tendencies may be present and protective measures may be necessary. The usual precautions in treating patients with impaired renal or hepatic function should be observed.

Side effects: In clinical use, fatigue, drowsiness and ataxia have been reported; in most instances these are dose-related and may be avoided by proper dosage adjustment. Mild nausea and dizziness may occur on occasion. As with any new agent, when it is administered for protracted periods of time, periodic blood counts and liver function tests are advisable. Abrupt cessation after prolonged overdosage may, in some patients, produce withdrawal symptoms (e.g., convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and Librium® (chlordiazepoxide HCl). Changes in EEG patterns have been observed in patients during and after Valium (diazepam) treatment.

Paradoxical reactions, such as excitement, depression, stimulation, sleep disturbances, acute hyperexcited states and hallucinations have been reported. Other side effects noted have been blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash.

Valium (diazepam) is available as 5-mg and 2-mg tablets. For convenience and economy in prescribing, both strengths are supplied in bottles of 50.

Roche Laboratories endorses the principle of caution in the administration of any therapeutic agent to pregnant patients.

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